DOCUMENT RESUME

ED 176 431 EC 120 115

TITLE A Direction Center for Handicapped Students. Technical Report No. 6.
INSTITUTION Texas Education Agency, Austin. Learning Resource Center.
PUB DATE Apr 79
NOTE 295p.
AVAILABLE FROM Texas Education Agency, 201 E. 11th Street, Austin, Texas 78701 ($3.00)

EDRS PRICE MF01/PC12 Plus Postage.
DESCRIPTORS Consultation Programs; *Educational Programs; *Handicapped Children; *Information Centers; Referral; *Resource Centers; *State Agencies; *State Programs
IDENTIFIERS *Direction Service Center (Texas)

ABSTRACT

The report provides an overview of direction service for handicapped students in Texas, explores the issues involved in planning a direction center, describes in detail the State Direction Service Center (SDSC) in Texas, and presents the training materials used by the SDSC to train both state and regional-level staff. Direction service is defined as an information based service designed to match periodically and systematically the needs of a handicapped child to the proper combination of services to satisfy those needs. Six major areas of concern in the development of a direction service center are analyzed: the pilot program, the target population, methods, for directing the client to the services and for surveying resource agencies, the development of a client and resource information bank, the setting up of advisory committees, and accountability. The operation of the SDSC is discussed in terms of its resource and referral components, and the information bank generated by the resource component is described. The bulk of the report consists of the training activities for the resource and referral specialists of the SDSC. Included among the 15 appendixes are a sample information referral form, a sample staff time log, and a list of specific eligibility requirements. (DLS)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED176431

A DIRECTION CENTER
FOR HANDICAPPED STUDENTS

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

After the original free distribution to authorized institutions, additional copies may be purchased for $3.00; however, with the increasing demand for educational material, the supply at times may be exhausted.

Since Texas Education Agency publications are not copyrighted, any or all sections of this bulletin may be duplicated.

Texas Learning Resource Center
Department of Special Education
Division of Developmental Services
Texas Education Agency
Austin, Texas
April 1979

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

Linda Kemp

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

EC 120115

COMPLIANCE WITH TITLE VI, CIVIL RIGHTS ACT OF 1964; TITLE IX OF THE EDUCATION AMENDMENTS OF 1972; AND THE MODIFIED COURT ORDER, CIVIL ACTION 5281, FEDERAL DISTRICT COURT, EASTERN DISTRICT OF TEXAS, TYLER DIVISION

Reviews of local education agencies pertaining to compliance with Title VI Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; and with specific requirements of the Modified Court Order, Civil Action No. 5281, Federal District Court, Eastern District of Texas, Tyler Division are conducted periodically by staff representatives of the Texas Education Agency. These reviews cover at least the following policies and practices:

(1) acceptance policies on student transfers from other school districts;

(2) operation of school bus routes or runs on a non-segregated basis;

(3) non-discrimination in extracurricular activities and the use of school facilities;

(4) non-discriminatory practices in the hiring, assigning, promoting, paying, demoting, reassigning, or dismissing of faculty and staff members who work with children;

(5) enrollment and assignment of students without discrimination on the basis of race, color, national origin, or sex;

(6) non-discriminatory practices relating to the use of a student's first language; and

(7) evidence of published procedures for hearing complaints and grievances.

In addition to conducting reviews, the Texas Education Agency staff representatives check complaints of discrimination made by a citizen or citizens residing in a school district where it is alleged discriminatory practices have occurred or are occurring.

Where a violation of Title VI of the Civil Rights Act and/or Title IX of the Education Amendments of 1972 is found, the findings are reported to the Office for Civil Rights, Department of Health, Education and Welfare.

If there is a direct violation of the Court Order in Civil Action No. 5281 that cannot be cleared through negotiation, the sanctions required by the Court Order are applied.

This publication was developed by Texas Education Agency staff and is designed for use by Education Service Center personnel in developing and implementing their regional Direction Centers. Comments and suggestions for improving the publication are welcome and will be included in subsequent revisions.

M. L. Brockette

M. L. Brockette
Commissioner of Education

PREFACE

The goals of this technical report are:

Goal 1

> To provide an overview of direction service and its development in Texas.

Goal 2

> To explore the issues involved in planning a direction center.

Goal 3

> To describe in detail the State Direction Service Center (SDSC) developed and implemented in Texas.

Goal 4

> To present the training materials which are used by the SDSC to train both state and regional-level staff persons in the functions of a direction service center.

Chapter 1 traces the origin of direction service and gives a brief history of the development of direction service in Texas. The concept was initially outlined in general terms by the Bureau of Education for the Handicapped (BEH), U. S. Office of Education. It was put into operation at the state level by the Texas Education Agency (TEA) and subsequently was implemented within the 20 regional education service centers (ESCs). In Texas, the ESCs are intermediate service units which provide a link between the state and local education agencies.

Chapter 2 analyzes six major areas of concern in the development of a direction service center. Although each center will evolve differently as it adapts to its own setting, each of these issues represents an area in which policy decisions will have to be made as the center becomes operational.

Chapter 3 delineates the operation of the two components of the SDSC. The resource component gathers and organizes information on resources providing services to the handicapped. The referral component matches the needs of handicapped clients to the most appropriate services available to meet those needs. The procedures by which each component functions are explained in step-by-step narratives and are illustrated by flow charts.

Chapter 4 describes the information bank generated by the resource component and demonstrates how it is used to locate services for clients.

Chapter 5 presents the materials developed by the SDSC for training persons in the operation of the resource component.

Chapter 6 contains training materials for the referral component. These materials were developed for use in workshops where regional ESC staff members were trained so that each ESC could implement its own direction service center. The materials are used to train new persons as staff turnover requires. By training regional staff members, the state helps to ensure uniformity in general procedures but allows each center the flexibility to adapt to the unique needs of its region.

These materials are not intended to function as a self-guided training package, but can be modified and adapted to assist other centers in developing their own training programs.

A glossary has been included to help the reader understand the terminology of this report. Some of these terms have been borrowed from other contexts and given specialized meanings within the Texas State Direction Service Center, and some have been coined as the Center developed.

TEXAS EDUCATION AGENCY

STATE BOARD OF EDUCATION
(State Board for Vocational Education)

MRS. ELIZABETH R. ARMSTRONG, Lake Jackson
JAMES M. BINION, Abilene
JOE KELLY BUTLER, Houston
W. W. CARTER, Amarillo
DON H. COOK, D.D.S., Mesquite
BRYAN CROUCH, Poteet
DR. VIRGINIA CURREY, Arlington
JIMMY L. ELROD, San Antonio
W. H. FETTER, La Marque
WAYNE FREDERICK, Orange
JOSEPH C. GATHE, M.D., Houston
E. R. GREGG, JR., Jacksonville
RUBEN E. HINOJOSA, Mercedes
JIM HOLLINGSWORTH, De Soto
WILLIAM N. KEMP, O.D., Houston
MRS. MARY ANN LEVERIDGE, East Bernard
PAUL MATHEWS, Greenville
REX REDDELL, San Marcos
RICHARD TENIENTE, San Antonio
MRS. LAURA TYNES, Waco
MRS. MARJORY VICKERY, Lewisville
JAMES H. WHITESIDE, Lubbock
WAYNE WINDLE, El Paso

M. L. BROCKETTE, Commissioner of Education
(Executive Officer of the State Board of Education)

L. HARLAN FORD, Deputy Commissioner
for Programs and Personnel Development

ALTON O. BOWEN, Deputy Commissioner
for Administrative Services

J. B. MORGAN, Associate Commissioner,
Policies and Services

ACKNOWLEDGMENTS

This publication was developed by a writing committee from the Texas Education Agency.

Anthony C. Howes
Dennis Ferrell
Sharon Snapp
Linda Walker

The material was reviewed by the following Agency and Education Service Center persons mentioned and their comments were incorporated into the report.

Janet Blum
Jack Himes
Margaret Fletcher
Robert Stice
Luke Martin

The finished publication was edited by Judy Overton.

Special recognition is given to James A. Tucker who had major responsibility for overseeing the project.

Table of Contents

Page

Introduction 1

Chapter 1 Origin of Direction Service 3

Direction Service in Texas 7

Chapter 2 Developing a Direction Center 11

Pilot Concept 13
Target Population 15
Methods for Directing the Client to the Services and for Surveying Resource Agencies 16
  Person-to-Person Method 17
  Questionnaire Method 18
  Telephone Communication Method 20
  Conclusions 21
Development of Client and Resource Information Bank 21
  Deciding What Information to Collect 22
  Identifying Resources and Evolving a Method of Client and Resource Information Collection 23
  Storage and Retrieval System 24
  Validation of Resource and Client Information 25
Advisory Committees 27
Accountability 29
  Quantitative Data 30
  Qualitative Data 32
    Consumer Qualitative Data 32
    Inferred Qualitative Data 33

Chapter 3 State Direction Service Center Components 37

Referral Component 39
Resource Component 49
Computerized Information Bank 53

Chapter 4 The Resource Information Bank 55

Resource Files 57
Level I Form 59
  Identifying Information 59
  Service Classification 60

Table of Contents (continued)

Page

Level II Form 62
  Service Classification Grid 62
  Fee Information 63
  Duration of Service 63
  Type of Client Served 63
  Program Information 64
Information Bank Retrieval 65
  Part 1 66
  Part 2 68

Chapter 5 Training Activities for the Resource Specialist 69

Procedural Guide 75
Level I Form 75
  Data Base Maintenance Information 75
  Determining the Number of Level I Forms 75
  Identifying Information 76
  Service Classification Grid 81
Level II Form 81
  Service Classification Grid 81
  Special Modes 85
  Service Wait 86
  Duration of Service 86
  Primary Client Type Served 86
  Program Information 87
Exercise 1: Selecting Names for Resources 89
  Key to Exercise 1 91
Exercise 2: Identifying Types of Clients 92
  Key to Exercise 2 94
Exercise 3: Classifying Services 95
  Key to Exercise 3 98
Transcript I: Survey of McDonald School 99
  Level I Survey Form: McDonald School 105
  Level II Survey Form: McDonald School 106
  Discussion of Levels I and II Survey Forms: McDonald School 109
Transcript II: Survey of St. Joseph Treatment Center 110
  Level I Survey Form: St. Joseph Treatment Center 117
  Level II Survey Form: St. Joseph Treatment Center 118

Table of Contents (continued)

Page

Discussion of Levels I and II Survey Forms: St. Joseph Treatment Center 130

Chapter 6 Training Activities for the Referral Specialist 135

Case Management 139
Setting Limits for Confidentiality 147
Advocacy 152
Capabilities of a Direction Center 157
Drawing Conclusions Based on Unconfirmed Data 160
Creating Unrealistic Expectations for the Referring Agent 163
Setting Priorities 167
Data Gathering and Needs Assessment 174
Confidentiality of Client Records 184
Using the Resource Information Bank 189
Unavailable Services 193

Appendix A
Developmental Evaluation Service Intake Sheet 197

Appendix B
Information Referral Form, Level I 215

Appendix C
Texas Regional Resource Center Referral Form, Level II and III 219

Appendix D
Staff Time Log 225

Appendix E
Contact Log 229

Appendix F
Level I and Level II Survey Forms 233

Appendix G
RRC Consumer Feedback Form, Level I 239

Appendix H
RRC Consumer Feedback Form, Level II and III 243

Table of Contents (continued)

Page

Appendix I
Definitions of Categories and Subcategories of Service 247

Appendix J
Types of Clients 255

Appendix K
Survey Respondent Thank You Letter 261

Appendix L
Information Bank Request Form 265

Appendix M
Data String Descriptions 269

Appendix N
Specific Eligibility Requirements 279

Appendix O
Referral Transcript 285

Glossary 297

INTRODUCTION

Definition of Direction Service

Direction service is defined in this report as an "information-based service designed to match periodically and systematically the needs of a handicapped child to the proper combination of services to satisfy those needs."

An "information-based" direction service relies on in-depth information about each child and family and on comprehensive information detailing all available services required to meet the identified needs. "Periodic" implies regular follow-up to ensure that the services can be modified as the child grows older, improves in response to services received, or as more appropriate services become available. "Systematic" means that standardized procedures are established for determining the comprehensive needs of each child and for matching those needs with the most appropriate available services. To establish these procedures requires the development of consistent, integrated definitions for the entire spectrum of specialized services, plus a wide variety of disabilities and handicapping conditions. A "proper combination" is a mix of several services which are necessary to meet the client's needs. The coordination among multidisciplinary service providers required to obtain this mix is a key feature of direction service.

As defined here, "direction service" does not include the actual delivery of direct services such as physical therapy or specialized instruction. In some settings, however, it may be beneficial for a direction center to provide some direct services such as diagnosis, counseling, or transportation. Factors which will affect the decision whether to provide these services include the environment within which the direction service center is developed, the availability of such services within the community served by the center, and the level of funding for the center.

Chapter 1

ORIGIN OF DIRECTION SERVICE

ORIGIN OF DIRECTION SERVICE

In February of 1972, the Assistant Secretary for Planning and Evaluation of the U. S. Department of Health, Education, and Welfare (DHEW) contracted The Rand Corporation to conduct a comprehensive evaluation of federal and state programs and policies related to services for handicapped children and youth. The stimulus for this project was the belief held by many federal officials that the network of institutions responsible for providing human services was failing to respond to our society's needs. DHEW asked The Rand Corporation to evaluate a portion of this network in terms of its effectiveness as a system for the provision of services to one segment of the population. Visually and auditorially handicapped children and youths were chosen as the target population primarily because, relative to other populations, these persons interact with the system in ways which generate records and case histories. From this investigation DHEW hoped to develop an evaluation model which could be applied to other portions of the system.

The Rand Corporation published its findings in two reports. The first report (Kakalic, Brewer, Dougharty, Fleischauer, & Genensky, 1973) assessed the current status of services to this population and presented analyses of several major problems within the system. The second report (Kakalic, Brewer, Dougharty, Fleischauer, Genensky, & Wallen, 1974) evaluated public policies regarding the handicapped and suggested modifications to improve the delivery of services. The authors were careful to gather their data from many different segments of the service system and from a wide sampling of the consumers of the services. They anticipated that perceptions of the system and its problems would vary widely among different groups such as handicapped individuals and their families, service providers in the private sector, and persons working within the various federal and state bureaucracies.

The reports revealed many serious deficiencies in the existing system of services. The authors acknowledged that many of these are related to insufficient funding and a scarcity of resources; however, they emphasized that increased funding alone will not solve the basic problems with the system. These problems are rooted in the complexity and fragmentation of the system. The system is complex because of the wide variety of professionals and large number of public and private agencies providing services to the handicapped. It is fragmented because so few channels of communication exist by which one segment of the system can provide information to another. Without this communication, it is impossible to conduct thorough needs assessments or to draw accurate conclusions regarding the relative supply and demand for specialized services.

The problem most often voiced by parents of handicapped children is the lack of guidance in finding the services needed by their children. Two thirds of the parents interviewed reported they did not know where to look for services or were unable to express their needs in the terminology of the system. In many cases a child and family are shuffled through a series of agencies, hopeful with each new program that they have finally discovered the most appropriate resource. During this process individuals and agencies can overlook and sometimes misplace records, causing duplication of previous evaluations and other services. Finally, overwhelmed by the futility of their efforts or unable to afford a seemingly endless sequence of evaluations and long-distance telephone calls, they often give up their search and settle for inadequate services. Kakalic et al. attribute this situation to the "specialty-centered" nature of the service system. This description refers to the fact that agencies and professionals usually provide a narrow selection of specialized services, whereas a handicapped child typically needs a comprehensive array of these services. The Rand report urges the system to become "child-centered" and to consider children in terms of their total service requirements.

The solution suggested by Kakalic et al. was to create a nationwide network of regional direction centers. In brief, they proposed that these centers:

1. Develop a centralized service to match the child's total needs with available services.

2. Emphasize a dynamic orientation to each case which will be responsive to changes in the child's needs over time.

3. Maintain comprehensive information on services available to the handicapped.

4. Coordinate a multidisciplinary effort to balance and integrate the specialized services needed by the child.

The authors predicted that the centers would benefit not only handicapped children and their families, but also the service system itself. Centralized coordination of the search for appropriate services and the provision of those services at the proper time in the child's development can reduce duplication of effort and eliminate the need for many other services as the child grows older. The information base generated by the center can help smooth out the uneven distribution of services and promote high standards of quality throughout the network of service providers.

Direction Service in Texas

In November 1974, the Texas Regional Resource Center (TRRC), a special project of the Texas Education Agency, was funded by the Bureau of Education for the Handicapped to implement a zero-reject referral system which incorporated the major features of Kakalic et al.'s direction service model. The system's goal was to identify appropriate educational services for every handicapped child referred. Federal guidelines determined that the target population for this project was the "complex, rare, and inexplicably handicapped" child and his or her family who had exhausted all local resources prior to referral to the zero-reject system. A statewide advertising effort publicized a toll-free WATS number so that anyone living in or moving to Texas could refer him or herself or a handicapped child for assistance in obtaining educational and specialized services.

The objectives of the TRRC, which administered the zero-reject system, were to determine the specific problems and special needs of each child referred, to achieve the best possible match between those needs and currently available services, and to re-examine periodically each case so that the selection of services could be adjusted with the child's changing needs.

To accomplish the objectives, two interdependent components were established within the zero-reject system. The resource identification component surveyed resources within the state which offer services to handicapped children or their families and maintained this information in a fashion organized for easy use by the referral component. The referral component accepted referrals via telephone, established client needs, provided information about existing services, offered assistance in contacting and negotiating with agencies for these services, followed up each case at established intervals to ensure the continued appropriateness of services, and helped locate new services if needed.

Because of the success of the system and the ability of key personnel within the Texas Education Agency to envision the advantages of moving this service into regional and local levels of education, the Agency in February of 1977 assumed the responsibility for funding the zero-reject system. At this time the name of the project was changed to State Direction Service Center. A few months later the Bureau of Education for the Handicapped made available to the states large sums of money as legislated by Public Law 94-142 for the purpose of identifying handicapped children who were not receiving educational services. This project was publicized nationally as Project Child Find. TEA personnel realized the potential of the referral system already established by the State Direction Service Center to serve as a vehicle to assist in the state's Child Find effort.

Therefore, the Agency funded each of the 20 regional education service centers to conduct intensive child find efforts. The State Direction Service Center was asked to help the regional education service centers identify handicapped children and locate services to meet their needs. Through statewide publicity the public was made aware of the services of the Center. When referrals were received, the Center coordinated efforts with the regional education service center responsible for the geographic area in which the referred child resided. Once these children were identified, it became the responsibility of the local school districts to provide services to meet their needs. The regional ESCs, in their efforts to assist the local school districts, expanded the focus of their Child Find projects to include the identification and delivery of educational and related services.

TEA felt that implementation of the State Direction Service Center's model would be the most effective method for the ESC to fulfill its expanded role. Therefore, in July of 1976 TEA funded each ESC for the purpose of developing direction service centers. The State Direction Service Center provided training and technical assistance to each ESC as it implemented its direction service operation. The State Center continues to coordinate the referral and resource functions of all the centers. The training and assistance have been provided through several workshops, in which separate training was offered for persons working in the referral component and in the resource component. Meetings are held quarterly to provide an opportunity for ESC staff members to discuss current issues, propose modifications in the system, and plan future activities.

Thus, the development of direction service in Texas has been a process of transforming the broad guidelines given in The Rand Corporation's report into a working model at the state level. Professionals from the Center then provided the training and technical assistance to implement this model at the ESC level. Chapter 2 discusses general issues involved in the development of any direction service center and presents some of the advantages and disadvantages associated with different approaches to these issues.

References

Kakalic, J. S., Brewer, G. D., Dougharty, L. A., Fleischauer, P. D., & Genensky, S. M. Services for handicapped youth: A program overview. Santa Monica, Ca.: The Rand Corporation, 1973.

Kakalic, J. S., Brewer, G. D., Dougharty, L. A., Fleischauer, P. D., Genensky, S. M., & Wallen, L. M. Improving services to handicapped children. Santa Monica, Ca.: The Rand Corporation, 1974.

Chapter 2

DEVELOPING A DIRECTION CENTER

DEVELOPING A DIRECTION CENTER

The State Direction Service Center is located at 150 East Riverside Drive in Austin, Texas. During the initial 15 months of operation, the Direction Center discovered major areas that must be addressed when setting up a direction service center. This chapter presents these areas and details the advantages and disadvantages of different methods of operation in these areas. The choice of these methods will vary with each direction service center as a function of its unique capabilities and limitations. The six major topics of concern are:

1. Pilot Concept
2. Target Population
3. Methods for Directing the Client to the Services and for Surveying Resource Agencies
4. Development of Client and Resource Information Bank
5. Advisory Committees
6. Accountability

Pilot Concept

Because it is difficult to anticipate problems that arise when implementing a direction center, it is wise to consider a pilot program using a subset of the eventual target population. Types of individuals who will contact the center, types of handicapped persons who will be referred, and types of services that will be requested are key points to anticipate. A pilot program might serve only a certain handicap, age group, or geographic area, and only after an opportunity to determine who will use the service and to correct problems in the delivery of those services would the program be expanded to serve a broader range of handicapping conditions, ages, or larger geographic areas.

A pilot program provides an opportunity to discover and correct problems in (1) identifying and surveying resource agencies, (2) storing survey information, (3) directing the referred child to appropriate resources, and (4) evaluating the effectiveness of the direction center when the amount of information, time and paperwork are in easily managed proportions. For example, particular resources and the specific services they provide must be located and delineated and a system for storing and retrieving the information must be in place. Collecting and compiling the information in a standardized fashion allows its effective use. Revisions in the survey content and format are inevitable until the information collected provides maximum assistance to the staff responsible for directing the handicapped child and family to the services. Only after the survey form has evolved can a system be developed to store information. The system must be suitable for the type and amount of information being collected and must provide easy access to key features of the information bank such as handicapping conditions, services, eligibility factors, and fees. Regarding the comprehensive needs assessment for clients, procedures should be developed and strictly adhered to if the process of determining the clients' needs and subsequently directing them to appropriate resources is to be a smooth, well-managed operation. The issues of confidentiality and advocacy are examples of important issues with which each direction center must deal. Developing policies and procedures regarding them requires trial and error learning which can be more easily managed and assessed if a pilot program is implemented. Evaluation of the pilot program determines the changes that should be incorporated into normal operating procedures. Consumer feedback regarding the delivery of direction service is necessary to determine changes to be made so the program will better meet the needs of clients; these changes can be made more easily during a pilot stage of program implementation.

A pilot program may not eliminate the entire gamut of problems encountered when expanding the direction service activities to a larger population. However, it will prepare staff members to anticipate problems before they become major obstacles. The rest of this chapter explores specific issues that must be resolved when developing a direction service center. The usefulness of a pilot program will become inherently clear as each of these issues is examined.

Target Population

An initial task in developing a direction service center is to establish the parameters of the geographic area and handicapped (target) population to be served. The population can be defined along such dimensions as type of handicap (blind, emotionally disturbed), degree of handicap (mild, severe), age range (preschool, adolescent), and geography (a certain city, certain counties). An example of a target population might be mildly retarded, preschool children residing in Harris County (Houston, Texas).

The primary client of direction service is the handicapped individual; however, parents, guardians, school personnel, and other case workers in a general sense can also be considered clients. This is especially true of parents, because a referral specialist may often find it necessary to direct parents as well as the handicapped child to appropriate services.

Selection of the target population should be guided by determining the specific geographic and handicapped populations that will benefit most from receiving the service. In addition to the population dimensions described above, other factors to consider are: whether to serve high-incidence populations, i.e., educable mentally retarded, or low-incidence populations, i.e., deaf-blind; whether to serve populations for whom services abound or to serve populations for whom services are rare. Additionally, the priorities of both the funding source and the agency within which the direction service is established will influence and perhaps restrict the choice of geographic and handicapped populations. For example, the funding source might specify severely handicapped children as the primary population to be served, while the governing agency might prefer focusing on severely handicapped preschoolers within a rural area of the state.

Once the parameters of the target population are decided, one must determine the services required. For example, one must decide whether to provide information pertaining to noneducational services in addition to educational services. The direction service advisory committee, discussed elsewhere in this chapter, can help make these decisions. Providing noneducational services such as food, clothing, and shelter is usually the responsibility of other local and state agencies.

However, maintaining limited information regarding these resources may be beneficial in directing clients to services which are not the primary focus of the center.

Methods for Directing the Client to the Services and for Surveying Resource Agencies

After the target population is established and the services that correspond to the needs of the intended population are identified, it is necessary to examine methods for directing the client to appropriate services and for surveying resource agencies which provide the necessary services to meet the client's needs. Numerous factors influence the determination of the most efficient method. Some of these factors are:

1. Level of project funding.
2. Size of the geographic area served.
3. Anticipated number of referrals during a specific time period.
4. Accuracy and comprehensiveness of child and resource data collected.
5. Degree of personal contact with clients and resource agencies.

The amount of money available to provide direction service dictates the method for interacting with the client and the manner in which resource agencies will be surveyed. It is much cheaper to send a questionnaire to an agency than to visit the agency personally. Providing direction service to a large geographic area creates problems regarding travel distance. Telephone contact may be less costly. A densely populated area will generate many referrals. If the referral specialist staff is limited, then telephones might be used to provide direction to the client; this would allow the staff to process more referrals by maximizing the use of their time. Depending on the importance assigned to developing an information bank of resources, a questionnaire, telephone, or in-person contact method could be used to collect information regarding the specific services provided by resources. An information bank comprised of very detailed resource data would require a complicated set of procedures to ensure the accuracy of the information, whereas an information bank comprised of the names, addresses, and phone numbers of the resources may only require that a simple questionnaire be sent to the resource to ensure accuracy of the information. Some methods provide a more personal dimension to the direction center staff member, who must interact with the client and the agency that delivers services.

Three major methods can be used to provide direction service. There are advantages and disadvantages to each. The methods best suited for any center will be influenced by factors unique to its needs.

Person-to-Person Method

Both referral and resource specialists may use this method. The client and family (guardian, advocate) come in person to the center to meet with a referral specialist to identify the needs of the handicapped individual. If the client can not come to the center for valid reasons, the referral specialist will meet at a convenient location with the client and family. This may be in the home of the client or in a school located close by.

When surveying resource agencies, the resource specialist will visit each agency to ascertain the services offered, for whom they are intended, and the manner in which these services are provided. Normally this can be done during one visit to the resource. In the course of identifying the client's needs and identifying specific services to meet those needs, repeated personal contacts might be necessary between the family/client and referral specialist.

A center that has direct contact with its clients and surveys resource agencies person-to-person has some distinct advantages. Face-to-face interaction with the referred child and the family lends a more personal dimension to the referral process. Parents or other referring parties experience a greater sense of being directly involved in finding solutions to meet the specific needs of the child. It is easier to establish rapport with a client when meeting in person, and this elicits more detailed and accurate information.

It is easier to explain solutions and answer questions about reports and services when both parties have the information before them. Person-to-person contact gives the referral specialist more control of case management. The person-to-person method is advantageous for the resource specialist, especially when performing on-site surveys. They provide the resource specialist an opportunity to tour facilities and meet agency staff members responsible for providing services. The resource specialist is thus likely to gain a more reliable perception of the resource agency and the quality of its services than if the survey was performed by a mailed questionnaire or a telephone interview.

The disadvantages of the person-to-person method relate to time, expense, and logistical problems. It requires more time and money to handle referrals in person, and it is often inconvenient and expensive for a referring party and client to come to the center, especially if they live in a different town. The person-to-person method requires more elaborate facilities, which is obviously more costly. The referral specialist is bound to more rigid time parameters when dealing with the clients in person and must set aside more time for professional preparation. It is also very time consuming to conduct on-site surveys, and the expense would likely be prohibitive if out-of-town agencies are to be surveyed.

Questionnaire Method

The questionnaire method is used only by the resource specialist, who collects information regarding the services agencies provide. Questionnaires are developed and then sent to resources with self-addressed, stamped envelopes. This enhances the possibility the questionnaires will be completed and returned to the direction center. Questionnaires can be used to collect very basic types of information such as names, addresses, and telephone numbers, or they can be used to collect more comprehensive types of information such as the types of services that are offered for the specific type of handicapped child and detailed information regarding eligibility factors for those services. The questionnaire ought to be sent at least annually to update the information bank; no interim contact would be necessary between the resource and the resource specialist.

The major advantage of this method is that it is inexpensive. After the questionnaire is developed it does not require a referral specialist to perform any type of survey. In other words, the questionnaire is a self-instructed instrument that requires no additional verbal interaction between the resource specialist and resource agency. Both the person-to-person method and the telephone method require considerable time from both parties in order to clarify items on the survey instrument.

There are many disadvantages involved in using the questionnaire method. One is that the resource agency, which is already overburdened with paper work, may not fill out the questionnaire. Another is that the information requested on the questionnaire is subject to misinterpretation because definitions and frames of reference differ. The complexities, and often the impossibility, of conveying exactly what information is being sought can create confusion and frustration among resource agency personnel and can cause inconsistencies in the information being collected. Misinformation regarding eligibility criteria for a particular service or the definition of an emotionally disturbed child are very good examples of items that, if misinterpreted, create confusion and inconsistencies. Another disadvantage is that the resource specialist must accept the information received at face value; telephone or on-site contact allows one to draw conclusions from clues given throughout the contact. This is not to imply that resource agencies will attempt to misrepresent themselves. Rather, it happens that resource agencies may inadvertently misrepresent themselves if the burden is on them to make judgments in the interpretation of specific elements of the questionnaire.

Finally, the opportunity to establish rapport with individuals within the resource agency is limited when the only contact is by mail. Establishing this rapport is extremely valuable and enhances the quality of information the resource will provide. Additionally, developing rapport with persons in resource agencies may prove valuable when and if a referral specialist must contact the resource regarding specific services for a handicapped child.

Telephone Communication Method

A third method of directing the client to a service is to use telephones to conduct the activities of the center. If the geographic area being served is large, toll-free telephones are advantageous. Resource agencies are surveyed, referrals are accepted, needs of the child are established, services for the child are identified, and systematic follow-up are accomplished by telephone.

There are strong arguments for using the telephone as the vehicle for providing direction service. First, more referrals can be processed. Because referral specialists have more control over their own activities they can structure their time and the client's more efficiently than if they were dealing with clients in a person-to-person manner. Similarly, the resource specialist can survey more agencies located over a wider geographic area than could possibly be done if on-site surveys were conducted. Second, the use of telephones makes direction service accessible to persons from a larger geographic area, and if the telephones are toll-free, they can be used by persons from all economic levels. In fact, if the direction service expects to serve a large geographic area, a telephone system may be the only alternative. Time, transportation, and financial considerations are reduced for the client when the handicapped individual is not required to come in person to the center. Another advantage is that overhead costs are reduced because a telephone system can be housed in a smaller facility than is necessary for person-to-person consultation. The final advantage is that telephone surveys offer the opportunity for extensive inquiry on the part of the resource specialist and respondent, which enhances the validity of the information being collected.

The disadvantages of the telephone communication method relate primarily to lack of person-to-person contact. The referral specialist must rely almost entirely on perceptions of a client that are developed in the absence of personal contact. Similarly, the resource specialist's perceptions of a particular resource are restricted to what has been communciated by telephone, which limits his or her knowledge of the facilities and staff members who provide the services. The telephone method is obviously not as personalized. It takes more time to establish rapport with the client and does not lend itself as well to fostering in the client a sense of being directly involved in the case management.

Conclusions

Each method for providing direction service has its distinct strengths and weaknesses. The choice of method will necessarily be influenced by factors such as the target population and geographic area to be served, the complexity of the resource data collected, and financial considerations. Of the three methods described, the person-to-person method is most appealing, the questionnaire method is least appealing, and the telephone comcunication method is most practical. Combinations of these methods are possible. The questionnaire method can only be used by the resource component; another method will need to be employed by the referral component. It may be feasible to use the person-to-person method for referral purposes and the telephone method for resource purposes. The resource component might use both the person-to-person and telephone communications methods, depending on the proximity of a particular resource agency. Similarly, the referral component could use both person-to-person and telephone methods, depending on the proximity of the referred child. Ultimately, the decision regarding the method of conducting the direction center's business usually will result in a trade off, with the most practical, rather than the most perfect, alternative being selected.

Development of Client and Resource Information Bank

Direction service is called an information-based service because its sole function is to provide information. Direct services are not provided; that is, direction service does not deliver (directly or through consultants) any type of formal assessment or programming services, but rather it provides detailed information to the client regarding where those services do exist. The term "information" refers to knowledge specific to a handicapped child, such as needs related to a handicap, the home environment, and educational program. It also refers to resources that provide services to meet those identified needs.

Four central issues are associated with developing systems to manage client and resource information: (1) deciding what information to collect, (2) identifying resources and evolving a method to collect information about them, (3) designing a system for storing and retrieving the information, and (4) creating procedures to validate the information that is collected. The following discussion considers these four issues, both with regard to resource data and to client data.

Deciding What Information to Collect

At the onset it will be difficult for the referral specialist to ascertain what type of client data must be gathered and what sequence of steps will best facilitate a smooth referral process. Experience in handling referrals will suggest revisions in the information being gathered. The type and depth of information needed by the referral specialist will vary depending on the level of involvement required to provide direction for a specific child. It may be appropriate to design different data collection forms (See Appendices A, B, and C) reflecting these different levels of involvement. Procedures must be established for securing the referred child's school records, medical records, and other confidential information in a manner which protects the privacy of the client and the confidentiality of the data.

It may also be difficult to determine resource data needs. Before one can determine the elements of information to collect, it is necessary to outline the proposed functions of the information bank. The primary function is to provide information to the referral specialist, who uses it to direct a client to appropriate resources. If the information bank is only going to be used as a directory, then names, addresses, and telephone numbers would be the key elements to collect. However, if the information bank will be used to provide detailed information about each resource and the services it provides, a more comprehensive approach is necessary. This is time consuming to develop initially, but it saves an enormous amount of time because it provides a complete description of the resource, which allows the referral specialist to spend more time with the client and less time contacting the resource personally.

The information bank might be used to provide knowledge of available resources to local and state referring agents such as school counselors and social workers. In this case one should consider their needs, a decision which influences the choice of information.

After the information structure has evolved, standardized forms can be designed for recording the information. It is crucial to build the capacity for modification into the system because revisions in the survey forms will most certainly become necessary as the direction service evolves. As referrals are dealt with, it will become obvious that certain types of information are a great deal more useful than others.

Identifying Resources and Evolving a Method of Client and Resource Information Collection

Several methods may be used to identify resources. Directories published by public agencies often contain brief program descriptions and referral procedures for each resource listed. One may request official reports, brochures, and other printed material from local and regional education units, mental health and mental retardation centers, public welfare offices, and other governmentally based agencies and private programs. Contacting both parent and professional organizations such as the Association for Children with Learning Disabilities and the Association for Retarded Citizens may yield information. Professionals with expertise in developing programs for children and who have knowledge of existing resources are another valuable resource. The direction center advisory committee is likely to contain several of these professionals. Another strategy is to ask the respondent of each resource surveyed for names of local agencies which provide significant services for the geographic area.

Client and resource information can be collected by one of several methods, which are discussed in "Methods for Providing Direction Service" in this chapter. Each of these methods could be used in the collection of information about resources; however, the method chosen should be based on the complexity of resource data collected. There are advantages and disadvantages to both the person-to-person and telephone methods of collecting client data. Obviously, the questionnaire would not be suitable for collecting client data.

Storage and Retrieval System

After deciding what elements of information to collect, a design for storing and retrieving it must be developed. The design should be responsive to the decisions which must be made by the referral specialist when dealing with a handicapped child and his or her family. The referral specialist needs to have access to a maximum amount of information in a minimum amount of time. Access to selected features of the information is also necessary. This can be accomplished if the system is designed to allow retrievals based on multiple variables. Consider these sample variables: (1) type of service, (2) type of client, and (3) county in which a service is available. For example, the referral specialist may be asked to locate a special education service for a blind client in Harris County. If the system is designed to allow access on these sample variables, the information can be retrieved in several ways:

1. Information on all agencies which provide special education services in Harris County.

2. Information on all agencies which serve blind children residing in Harris County.

3. Information on all agencies which provide special education to blind children residing in Harris County.

For small information banks a simple vertical file with each resource alphabetized in a labeled folder might be adequate. If cross-referencing is desirable, a key sort system allows for retrieval by more than one variable. The information can be placed on 3" X 5" cards with holes punched at identical locations for various key elements of information. A stylus inserted would retrieve only those cards that were identically punched. For example, a person looking for all resources in Texas that provide special education services for visually handicapped children would slip the stylus through the appropriate hole denoting special education. Of the deck remaining, the stylus would then be slipped through the hole which denotes special education services for visually handicapped.

For storing large amounts of information and retrieving on several variables, a computerized information bank is effective if monetary factors are not prohibitive.

For example, referring to the same three sample variables mentioned above, a computerized information bank could easily generate printouts that indicate all agencies which provide special education for blind children residing in Harris County. In addition to building into the storage design the retrieval capabilities, enough flexibility must be provided to allow information to be changed as a result of the survey updating process and to allow a change in access methods as survey priorities change.

If a computer-based retrieval system is to be used, one must decide first the maximum budget allocation, which is the first limiting factor in selecting among computer options. A consultant can aid in determining options for the money budgeted. This consultant should be familiar with the status of current computer technology and preferably should not be affiliated with a computer hardware company or be limited to knowledge of only one brand of machine. Options to be considered include leasing time, leasing hardware, time sharing on existing machines, and buying hardware.

Storage options for client data include vertical files and computers, or a combination of both. When designing forms and systems for storing and accessing client records, it is imperative to build in procedures that protect the privacy of the client and the confidentiality of the data.

Validation of Resource and Client Information

Organizational structures of agencies, the services they provide, and eligibility requirements vary widely among agencies, but more important, they change periodically within agencies. Because of this, collecting information offers many opportunities for inconsistency and error. If more than one resource specialist is responsible for this activity, the chances are multiplied dramatically. Because of intra-agency changes and changes in the needs of a client for those services, it is essential that the referral specialist be aware of these changes.

Validation of information is of primary importance. Validation refers to ascertaining the accuracy of the information being collected by the resource specialist from the agency being surveyed, as well as the accuracy with which the referral specialist has assessed the needs of the client. This concern applies to the initial information-gathering stage and to the periodic follow-up and updating of client and resource information. Achieving consistency in how the information is gathered, interpreted, and recorded is essential.

When developing the survey form for resource information, it is crucial to define explicitly each element of information to be collected. Unless information is collected and recorded in a standardized fashion it cannot be used effectively. These definitions also aid the resource specialist, who will encounter a monumental problem when trying to interpret agency terminology. For example, when a resource agency indicates that it serves learning-disabled children, the resource specialist must make certain that all parties are referring to the same type of handicapping condition.

Using more than one resource specialist magnifies the problem of standardization. Unless all specialists adhere to the same definitions and instructions when making decisions about recording information, the reliability and therefore the validity of the information bank will be undermined. The need for uniformity extends also to the referral specialists, who must share with the resource specialist a common set of definitions.

If information is to be stored in a computer, the survey forms should be designed for convenient coding by the resource specialist. This is also beneficial to the data processor, who must enter the information into the computer. Clerical errors in coding the survey forms can cause significant inaccuracies in the retrieval information.

As the survey process develops, systems need to be implemented to ensure the accuracy of the information. Different methods of surveying agencies generate different requirements for accuracy. For example, data gathered during a site visit is likely to be more accurate than data gathered by means of a mailed questionnaire.

The services provided by agencies, their costs, and client eligibility requirements change rapidly as priorities in funding, staffing, and administration change. For this reason, it is important to resurvey each agency periodically. A partial accuracy check is provided as direction service staff members use the survey information to process referrals, but a system should be in place to ensure that the information on every resource is updated at regular intervals. If the consumer of the service reports that the information is inaccurate or of little use, procedures can be originated either to alter the system for collecting the information or to revise the type of resource information collected. The frequency with which the information is reported to be inaccurate can help determine an optimum interval within which the surveys should be updated.

Accuracy of the information is paramount when the information is to be used in referring a handicapped child and his or her family to appropriate resources. Parents and local referring agents can assist the direction service center in maintaining accurate information if a consumer feedback feature is built into the referral process. Consumer feedback serves as an accuracy check with regard to the services a resource provides. Additionally, consumer feedback can provide an accuracy check for the referral specialist, who must pick and choose appropriate resources based on the needs of the client.

Advisory Committees

A carefully selected advisory committee can help the center plan its activities. The functions of the committee should be outlined prior to selecting individual members so as to ensure the best fit of the members to the functions they will be called upon to perform. In the planning stages of the direction service center, the committee can help design the operating procedures. As the service is implemented, the committee can establish initial priorities regarding the segments of the target population in greatest need of services and the areas of the service network which are the least understood or most difficult to obtain. Creating an advisory committee whose membership represents both the target population and the key service providers is an important step toward building a broad base of support throughout the area served by the direction service center. Committee members should have established positive relationships with community agencies so as to facilitate

36

communication regarding the needs of clients. A committee whose members have a solid foundation in the professional community and a reputation of responsiveness to high-priority needs of the target population can help the center elicit public support. This is beneficial if and when the center moves toward increasing dependence upon local sources of financing.

Organizations tend to make the best use of their advisory committees in the early stages of their operation, when the most difficult policy issues must be dealt with and when public awareness and outreach activities are most crucial. Often advisory committees are not used effectively once these initial stages are past. It is wise to anticipate and plan for long-range activities of the committee so that the interest and energy of the group does not dwindle over time. The advisory committee can fulfill its sense of action and accomplishment through a well-defined series of activities and through channels of communication which assure that its advice will not go unnoticed.

A good strategy for promoting coordination with all service providers is to include on the advisory committee representatives from the major agencies located in the geographic area served by the center. One function to which this group is especially suited is to serve as a "stymied case" committee. The knowledge and experience of the agency representatives provide fresh viewpoints or different approaches to problem cases. In addition, the committee can be a way for both consumers and service providers to work from a position of collective strength in confronting barriers to effective coordination and access to resources.

Another long-range activity of the committee is to funnel referrals to the direction service center. Cases which require services beyond the scope of any one agency can be referred to the center by a committee member with no loss of continuity in case management.

The advisory committee may be uniquely suited to perform periodic needs assessments. The goals of these assessments are to determine which services are high in demand but low in supply and to identify areas in which services are needlessly duplicated. A well-selected advisory committee will be invaluable in helping to solicit this type of information from community agencies. The stronger the relationship between committee members and community agencies, the greater will be the availability and accuracy of the information. The committee can also perform program evaluations. If the committee is carefully selected, its members can provide the expertise to devise an evaluation design which represents both a professional and consumer point of view. The evaluation may cover not only the services of the center, but also can include consumer evaluation of the services to which clients are referred.

Accountability

In order for a direction service center to continue to exist, it must prove its usefulness to its funding source and the community it serves; that is, it must provide enough facts to indicate it is a necessary service, one without which the community would suffer. This concept is one facet of accountability. Accountability is a means of supporting statements about the center's operation with verifiable facts and figures. On-going recordkeeping is essential to an efficient accountability system. There is no way to anticipate the types of figures and records which will be most useful in substantiating the merits of a direction service center; however, early planning can avoid many problems later.

In the case of federally or state-funded projects, the funding source will determine minimal criteria for accountability. However, equally important is the community which the center serves. Providing accountability information to community officials may be beneficial. For example, the number of caseworkers the center has assisted, or the number of school-age children the center has served can demonstrate the center's contribution to the community. This may prove helpful when the following year's funding level is being negotiated. Most accountability information is directly available from the normal course of operation, such as staff time logs. The rest can be generated from collecting, analyzing, and making inferences about certain types of information. Accountability information serves two major functions:

1. It allows the center to substantiate statements made to the funding source and public about its accomplishments. This type of accountability calls primarily for the

collection of quantitative data such as the number of children served or number of resources surveyed.

2. It allows the center to evaluate the quality of work that has been accomplished and thereby facilitates intelligent planning for the future. For this purpose qualitative data is valuable.

The following discussion is by no means an exhaustive description of the types of accountability information that could be collected in a direction service operation. Each direction service center will have its own needs, and its design will allow for the generation of different information. The types described below, however, are probably applicable to all direction service operations. Each of them can be directly tied to measurable outcome units.

Quantitative Data

This is "numbers" data, which demonstrates to funding agencies and the public the types of activities that are performed and the time that is spent performing them. This type of data, however, does not necessarily reveal how effectively the center is performing its work. Therefore, its value is minimal in planning future directions for the center without additional analysis and interpretation beyond its face value.

Some quantitative types of data that are important to collect are:

1. Number of referrals processed. Example: The Direction Service Center processed 95 referrals during the first quarter of 1978.

2. Number of resources surveyed. Example: The Direction Service Center surveyed 100 resources during the first quarter of 1978.

3. Staff time logs (See Appendix D--Time Log). Example: During the first quarter of 1978, 75 percent of staff time was spent on processing referrals and 25 percent was spent surveying agencies.

4. Contact log (See Appendix E--Contact Log). Contact logs contain detailed information about staff contact with people outside the center. This type of log is used to account for telephone contacts, direct in-person contacts, and incoming or outgoing correspondence contacts. Example: During the first quarter of 1978, 326 telephone contacts and 93 correspondence contacts were performed by the referral specialists in processing referrals. During this same time period, 176 telephone contacts and 71 correspondence contacts were performed by the resource specialists in the course of surveying agencies.

5. Client data. This type of data falls within two broad categories: unidentifiable client data and data which is child specific. Unidentifiable client data might include the child's handicap, age, and severity (See Appendix C--Referral Form). Example: During 1977, 50 severely handicapped children who were younger than three years of age were referred to the center.

   Child specific data might include such things as referral date, assessment date, agencies to which the child was referred, followup dates, and progress reports about the child. This type of data is frequently maintained in an individual child's folder for easy reference. Example: During the first quarter of 1978, John Doe received his six-month follow-up, which indicated that his current placement is providing positive results.

6. Referring agent data. Categorizing the referring agent by parent, school, intermediate education agency, state education agency, Department of Human Resources, Mental Health and Mental Retardation (See Appendix C--Referral Form) allows the center to verify who is using the service. Example: During the first quarter of 1978, 75 percent of the referrals were made by other major state agencies, 10 percent came from parents, and the remaining 15 percent from public schools.

7. Nature of referring agent request. Categorizing the nature of the request allows the center to determine the type of services that are most in demand (See Appendix C--Referral Form). Example: During the first quarter of 1978, 55 percent of all referrals included a request for residential treatment.

8. Service availability data (See Appendix F--Level I and II Survey Forms). Identifying services that are readily available and those that are scarce is beneficial to the referral specialist who must locate services for the handicapped. Example: Through the first quarter of 1978, an exhaustive search for agencies providing residential services for juvenile delinquents did not result in the identification of any additional resources providing those services.

Qualitative Data

These data are essential for evaluating the center's attempts to improve its services. Planning for qualitative data requires careful thought about the major goals and activities of the center and how to evaluate the efforts of the center to attain these goals. There are two types of qualitative data. The first, consumer qualitative data, is obtained by asking consumers to evaluate the quality of the services they have received. The second type of qualitative data is that which can be inferred from quantitative data. The following discussion presents the two types of qualitative data and provides statements that may be made about each type.

Consumer Qualitative Data

Consumer satisfaction deals both with the services rendered by the direction service center and the direct services provided by the agency to which the child and family were referred. (See Appendices G and H). This type of data allows the center to monitor the satisfaction of each client and family, and over extended periods of time the center can analyze its services and develop new policies and operating procedures to combat any consistent problems.

Example

> For the past two months consumer evaluation data reveal several instances where the family of the client has been dissatisfied with the length of time required by the center to identify appropriate resources for their child.

As a result of this type of data the center can explore the reasons for its slow response and modify existing procedures to correct the problem.

Information regarding consumer satisfaction with the services that particular agencies provide is helpful when the center directs clients to resources in the future.

Example

> For the past six months, consumer evaluation data revealed seven instances where families complained about a specific agency's inconsistent policies regarding the duration of time before a handicapped child can begin to receive services.

In this situation, the center might discuss the waiting list procedures with a representative of the agency.

Inferred Qualitative Data

This type of data refers to the formation of qualitative statements that are inferred from the collection and analysis of quantitative data. The next section takes the examples presented in the Quantitative Data section and presents sample questions. The answers to these questions are considered inferred qualitative data because they are qualitative statements based on analysis of quantitative data.

1. Referring agent data. Quantitative Data: During the first quarter of 1978, 75 percent of the referrals were made by other major state agencies, 10 percent came from parents, and the remaining 15 percent came from public schools.

   One goal of the direction center is to have, as the majority of its clients, parents and public school personnel who work with handicapped children. Yet most referrals are coming from state agencies.

Question

Can the center better publicize its services so as to increase the number of referrals from parents and public school personnel?

Answer

Different publicity strategies might be employed to increase referrals from parents and public schools. Any significant increase in the numbers of these types of referring agents could be attributed to different publicity strategies.

In this case, quantitative data were analyzed before and after methods of publicity were changed, and qualitative statements can be inferred regarding the extent to which the center has reached its intended population.

2. Nature of referring agent request. Quantitative Data: During the first quarter of 1978, 55 per cent of all referrals included a request for residential treatment.

Question

Can the center locate more resource agencies that provide residential treatment?

Answer

The resource specialists will conduct an exhaustive search to locate additional resources providing this service.

Again the careful analysis of quantitative data (number of agencies providing residential treatment) results in the generation of data which allow qualitative statements to be made. For example, an adequate supply of residential facilities does not exist to meet the demand by referring agents.

3. Service availability data. Quantitative Data: Only 5 percent of the requests received in the first quarter of 1978 for residential services for juvenile delinquents resulted in a child's being

placed in such a facility. In this same quarter, an exhaustive search for agencies providing residential services for juvenile delinquents resulted in the identification of no additional resources.

Question

> What other options should be explored in view of the fact that additional residential resources for juvenile delinquents have not been identified?

Answer

> Explore procedures to use with referring agents to determine more realistic service options. For example, if monetary considerations are prohibitive, then exploring this with the referring agent at the outset might save considerable time and focus attention on options for juvenile delinquents other than residential placement.

4. Child data. Quantitative Data: During 1977, 50 children referred to the center were younger than age three. Currently the center does not provide services for children under age three.

Question

> In order to meet the complete needs of the area served, should services be expanded to include children under age three?

Answer

> Study the factors that would influence a decision to expand services. For example, the fact that the public schools do not provide services to this age group might influence the decision. Another factor might be the cost in staff time to provide services for this age group or the availability of services if this type of referral is accepted. A decision to provide services to this age group would better meet the needs of the target population and

consequently would enhance the quality of services provided by the center at little extra cost.

5. Child data. Quantitative Data: The files reveal that six-month follow-ups were not completed for 30 percent of the children.

   Question

   What procedures can be developed to ensure that follow-up occurs with 100 percent accuracy?

   Answer

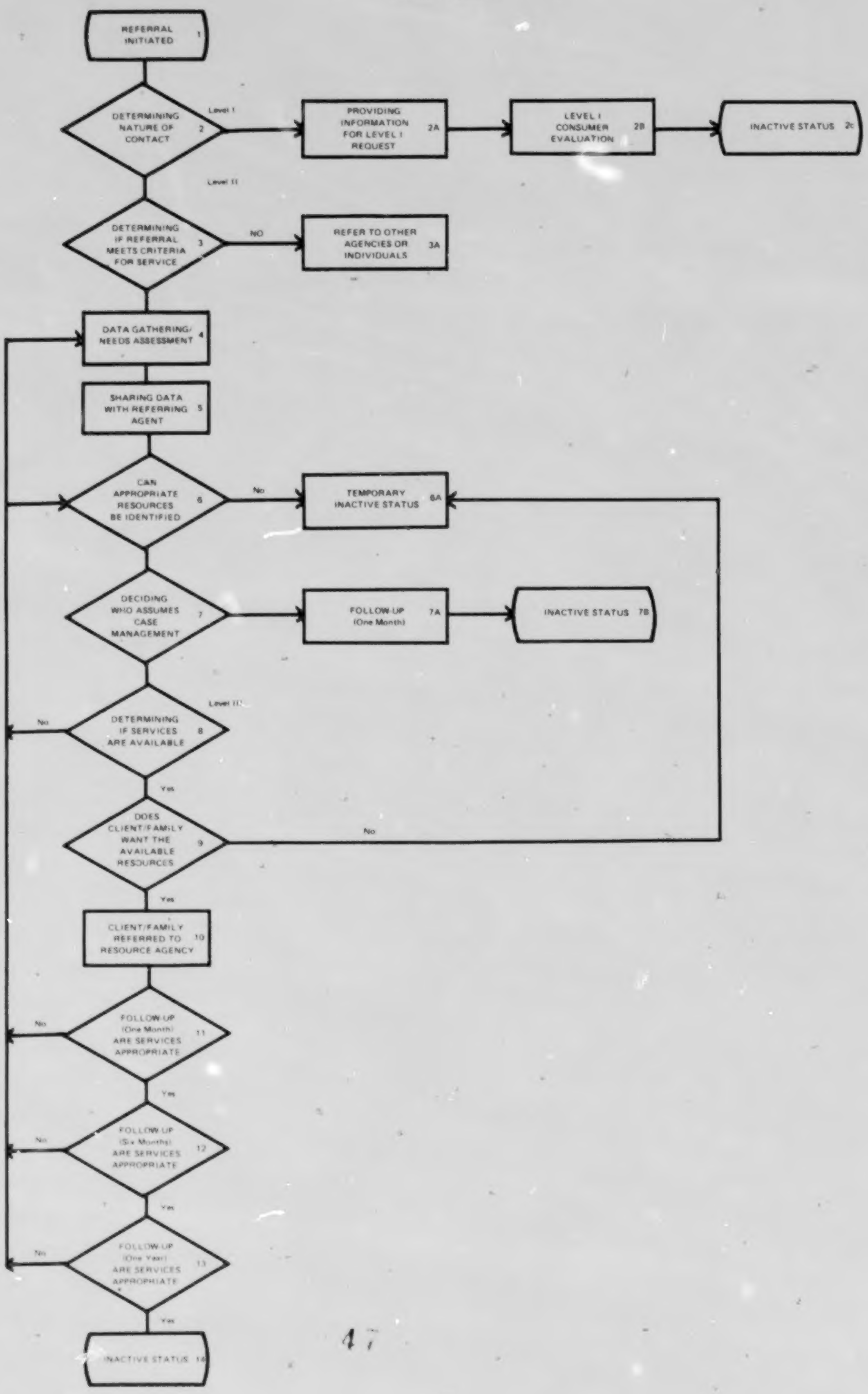
   Developing a filing system which enabled the referral specialist to file a child's folder under the month in which six-month follow-up occurred and requiring the referral specialist to check the file routinely for the current month would immediately flag the children who are scheduled for six-month follow-up that month.

This chapter has discussed the six major areas that every direction center must address in its initial developmental stage. Chapter 3 presents the process for operating both the referral and resource components of the State Direction Service Center, which has existed in Texas for more than three years. This operation has subsequently been moved into each of the 20 regional education service centers, with the major emphasis at the state level now being the provision of technical assistance and training for the regional centers.

Chapter 3

STATE DIRECTION SERVICE CENTER COMPONENTS

REFERRAL COMPONENT


REFERRAL INITIATED 1
DETERMINING NATURE OF CONTACT 2
Level I
PROVIDING INFORMATION FOR LEVEL I REQUEST 2A
LEVEL I CONSUMER EVALUATION 2B
INACTIVE STATUS 2c
Level II
DETERMINING IF REFERRAL MEETS CRITERIA FOR SERVICE 3
NO
REFER TO OTHER AGENCIES OR INDIVIDUALS 3A
DATA GATHERING/ NEEDS ASSESSMENT 4
SHARING DATA WITH REFERRING AGENT 5
CAN APPROPRIATE RESOURCES BE IDENTIFIED 6
No
TEMPORARY INACTIVE STATUS 6A
DECIDING WHO ASSUMES CASE MANAGEMENT 7
FOLLOW-UP (One Month) 7A
INACTIVE STATUS 7B
Level III
No
DETERMINING IF SERVICES ARE AVAILABLE 8
Yes
DOES CLIENT/FAMILY WANT THE AVAILABLE RESOURCES 9
No
Yes
CLIENT/FAMILY REFERRED TO RESOURCE AGENCY 10
No
FOLLOW-UP (One Month) ARE SERVICES APPROPRIATE 11
Yes
No
FOLLOW-UP (Six Months) ARE SERVICES APPROPRIATE 12
Yes
No
FOLLOW-UP (One Year) ARE SERVICES APPROPRIATE 13
Yes
INACTIVE STATUS 14

STATE DIRECTION SERVICE CENTER COMPONENTS

The State Direction Service Center (SDSC) is comprised of two components: the referral component and the resource component. Each component is staffed with at least one professional who specializes in the functions of that component, a procedure which has proven most effective in servicing an area as large and heavily populated as Texas. There is an extensive amount of interdependence and coordination between these two components. This coordination includes a shared computerized information bank, which simplifies record-keeping and accountability activities and allows flexibility in responding to the information needs of clients. Regular joint meetings of specialists and support staff from both components ensure coordination and a smooth flow of information within the system. The narrative which follows describes the operation of each component separately. A flow chart has also been included to accompany the narrative for each section.

Referral Component

Until direction centers were established in ESCs, the State Direction Service Center assumed responsibility for all case management activities for clients referred to the Center. Gradually more and more of the state's operation was assumed by the ESCs. Currently most referrals processed by the State Center fall into two categories: those made by individuals not currently residing in Texas and those made by ESCs in need of assistance with cases for which they have exhausted all local resources.

Case management encompasses a continuum of activities which begins with the actual acceptance of a referral and continues through follow-up. The responsibility for these activities is generally shared among the parent, referral specialist, and referring agent. The specific distribution of responsibility among these persons varies as a function of the abilities and skills of the parent and/or referring agent, the nature of the services needed, and the caseload of the referral specialist. In most instances the parent or other referring agent assumes primary case management responsibility after the family has decided to accept service from a particular resource. This responsibility includes keeping appointments, supplying agencies with documents and records, and contacting the referral specialist if assistance is needed prior to the scheduled follow-up times. It is important to keep in mind that parents are legally responsible for the overall welfare of their child. Thus, all final decisions concerning services for the child must be made by them.

The referral specialist, who directs the activities of this component, gathers all necessary information for each case, personally guides the case through the referral process, and follows up to see that the referred individual receives the appropriate services. The procedures followed are outlined in a flow chart and are explained in the following narrative.

Step 1. Referral Initiated

The SDSC publicizes its services through brochures, public announcements, and meetings with various agency personnel. As a result of these public awareness activities, the Center is contacted by many different sources, including parents, school personnel, charitable organizations, local education agencies, education service centers, the Department of Human Resources, the Department of Mental Health/Mental Retardation, legal and health authorities, and handicapped individuals themselves. These contacts are made by telephone via a toll-free number, by mail, and in person.

Step 2. Determining Nature of Contact

This step involves distinguishing between general information inquiries and client referrals. If an individual is being referred, the contact is considered a Level II or III referral and moves to Step 3, where the eligibility of the client is established and entry into the referral system occurs. If the contact is a request for information, it is a Level I referral and moves through Steps 2A, 2B, and 2C. Level I referrals range from those requesting information about a single agency (easily obtained from the survey form itself) to more complex ones asking for data on all resources within a particular geographic area that provide services to individuals with a certain type of handicap.

Step 2A. Providing Information for Level I Request

The referral specialist records the request on a standardized form (See Appendix B). Depending on the request, the referral specialist may respond immediately or may prepare an information packet which is mailed to the referring agent. This packet may include computer printouts and/or other written materials tailored for the specific request. These packets may serve a variety of purposes, including use with future clients or facilitation of health service planning in a particular community or region.

Step 2B. Level I Consumer Evaluation

One month after the request is made, a consumer evaluation form is mailed, accompanied by a stamped, self-addressed envelope to enhance the return of the form (See Appendix G). The consumer is asked to evaluate the quality and usefulness of the information provided. If the consumer feedback form indicates dissatisfaction, additional efforts are made to provide the desired information.

Step 2C. Inactive Status

After the evaluation form is returned and after the individual is satisfied with the information provided, the referral exits the system.

Step 3. Determining If Referral Meets Criteria for Service

Step 3 deals with those referrals which pertain to specific persons who currently reside or plan in the near future to reside in Texas. The target population includes anyone from birth through 21 years of age (22 years for visually or hearing impaired) who has special needs. Some of these persons have specific handicapping conditions which are defined by the Texas Education Agency. Eligibility criteria for these handicapping conditions are included in the Policies and Administrative Procedures for the Education of Handicapped Students. Others have special needs as a result of court designations such as juvenile delinquent, dependent neglected, and children in need of supervision.

The referred individual who meets these requirements becomes eligible for assistance from the State Direction Service Center until the referring agent or client wishes to exit the system. If the referral involves an individual with a suspected handicap, the client's eligibility for service is not determined until sufficient data are gathered (Step 4--Data Gathering/Needs Assessment). Individuals who are handicapped or have other special needs proceed to Step 4. Individuals who are not handicapped or who do not meet the other eligibility criteria proceed to Step 3A.

Step 3A. Refer to Other Agencies or Individuals

Individuals are referred to other agencies which may provide social, financial, and/or medical assistance. Care is taken to give the individual as many reliable sources of assistance as possible.

Step 4. Data Gathering/Needs Assessment

Information about the child and family comes from several sources. These can be parents, teachers, or other school personnel, welfare workers, medical personnel, and any other professional who has worked with or has knowledge of the child's needs. All information is considered confidential and is not released without parental consent. Case history begins with information exchange on the role of the referring agent in the case and basic information on the child's residence, birth date, problems, and needs. The referring agent's statement about the nature of the service request is recorded. Past and present educational experiences, current level of functioning, medical data, family history, other services received, and financial needs are essential pieces of information used to determine appropriate educational and related services. This information is compiled on two different sets of forms which are included in Appendices A and C.

Step 5. Sharing Data With Referring Agent

After the referral specialist has assimilated the information necessary to identify the client's needs, the referring agent is consulted. The information collected in Step 4 is presented, and service options are discussed. It is not uncommon for a child to receive several different diagnoses and recommendations for treatment, especially when the handicapping condition is unusual or complex. As a result, the information collected from other agencies and individuals sometimes contradicts the referring agent's original opinion of the client's service needs. The consultation can be a delicate matter if the needs assessment yields results radically different from the needs and requests originally stated by the referring agent. The referral specialist must rely on his or her experience and professional judgment when deciding how to resolve any conflict which may exist regarding the client's needs.

Step 6. Can Appropriate Resources Be Identified?

The referral specialist initiates a search for the service based on all available information. Several sources are explored, including the computerized information bank (described at the end of this chapter), the vertical resource files, catalogs, and directories. In some instances it may be feasible to modify an existing program or to create a new program for the handicapped individual. Occasionally the client may be placed in a program temporarily until other more appropriate services can be located. If an appropriate program can be found or created in the existing service delivery system, the referral proceeds to Step 7. If appropriate resources can not be identified, the referral proceeds to Step 6A.

Step 6A. Temporary Inactive Status

If there is no appropriate resource within a reasonable traveling distance from the child's home, or if the family does not want the services, then the referral may be put on temporary inactive status. These cases automatically re-enter the referral process at the end of six months, at which time follow-up occurs (Step 6).

Step 7. Deciding Who Assumes Case Management

Ideally case management responsibilities are shared by the referral specialist and referring agent. These responsibilities are determined by the degree to which the referring agent is capable of contacting potential service providers and following through until service is made available to the client. If the referring agent is a caseworker for a state agency, that individual would be expected to assume more of the case management responsibilities. In this case, the referral specialist's responsibilities would be limited to using client information to locate appropriate resources through the information bank, discussing those resources with the referring agent, and providing follow-up. Thus, a sharing of case management responsibilities exists, with the referring agent assuming the majority of those responsibilities. Under these circumstances, the referral is assigned a Level II status and proceeds to Step 7A.

If the referring agent is a parent who has been frustrated in his or her attempts to locate services or who does not know how to do so, it is likely that the referral specialist would assume major case management responsibility for contacting resources and confirming appointments with designated agency representatives. From that point the referring agent would be expected to assume responsibility for keeping appointments, presenting whatever documents are required by agency representatives, and following through with agency requirements. The referring agent is also responsible for again contacting the referral specialist to discuss decisions that were made as a result of the appointments with other agencies. During subsequent meetings between the referring agent and referral specialist, case management responsibilities may be reassigned in response to changing circumstances until services are obtained for the client. If the referral specialist and referring agent negotiate case management responsibilities in this manner, the referral is designated a Level III and proceeds to Step 8, which indicates detailed involvement on the part of the referral specialist.

Step 7A. Follow-up (One Month)

Referrals which do not require the referral specialist to assume case management responsibility are followed up one month after the information has been provided. A consumer feedback form with a stamped, self-addressed envelope is mailed to the referring agent. This form requests that the referring agent/parent evaluate the way in which the case was handled and whether they were satisfied with the services to which they were referred (See Appendix H). If a feedback form indicates dissatisfaction with the services provided by the resource agency, the referral specialist personally contacts the referring agent to determine the reason for it. If the referring agent requests the referral specialist to assume responsibility for case management because of the difficulty in obtaining services, the referral proceeds to Step 8, at which point it is considered a Level III referral. If on the other hand, additional needs assessment information is necessary, the referral re-enters the process at Step 4.

Step 7B. Inactive Status

When the client is satisfied with the services provided, the case is considered inactive and is closed unless the referring agent initiates a contact to the Center.

Step 8. Determining if Services Are Available

When services which seem appropriate are located, the availability of these services is explored. The referring agent is usually asked to take responsibility for contacting some of the resources that provide the services. The referral specialist assists by calling resources outside the local area. The parent is asked to make the appointment and the arrangements for transportation whenever possible. The issue of responsibility is a crucial one. It is essential that the referring agent be involved in both the decision-making process and in locating available services. If services are not available, the referral re-enters the process at Step 4, where the needs assessment and information gathering must be expanded to see if additional services are available. If services are available, the referral proceeds to Step 9. If services are not available, the referral re-enters the process at Step 4.

Step 9. Does Client/Family Want the Available Resources?

The referring agent (parent or other case manager) representing the client is asked to make the final decision with respect to which available services are most appropriate. The final decision is not made by the referral specialist because he or she is not the person who is ultimately responsible for the future of the client. If the parent or caseworker refuses any or all services, the referral specialist places the case on temporary inactive status until follow-up occurs (7B). Other situations, such as a family crisis or an overnight change in the child's needs, may cause the case to be placed on temporary inactive status until a later date. If the client and family want the available resources, the referral proceeds to Step 10. If the client and family reject the resources, the referral re-enters the process at Step 6A.

Step 10. Client/Family Referred to Resource Agency

At this point the client and his or her family are referred to the appropriate resources. If the case was researched carefully and the referring agent was appropriately involved, obtaining the service(s) may be as simple as arranging for transportation for the parents or the client or arranging for school or other agency representatives to begin home visitations prior to service initiation.

Occasionally there may be difficulties in obtaining the services because of waiting lists or a temporary interruption within the family or the service itself. If this causes serious delay in the client's receiving the service, it may warrant the location of other appropriate resources in a different geographic area until a service closer to the individual is available.

Step 11. Follow-up (One Month) - Are Services Appropriate?

The follow-up system helps to determine first that the client is receiving the services and secondly that they are appropriate and the client and family's needs are satisfied. If the client does not receive the services or they are deemed inappropriate, the referral re-enters the process at Step 4. If the services are appropriate, the referral proceeds to Step 12. If the services are not appropriate, the referral re-enters the process at Step 4.

Step 12. Follow-up (Six Months) - Are Services Appropriate?

The six-month follow-up assesses the continuing appropriateness of the services. If at this time it is discovered that the services being rendered have become inappropriate due to the changing needs of the client, the referral would re-enter the process at Step 4; however, if the agency can no longer provide the services needed by the client, the referral would re-enter the process at Step 6. If the services are appropriate, the referral proceeds to Step 13. If the services are not appropriate, the referral re-enters the process at Step 4 or Step 6.

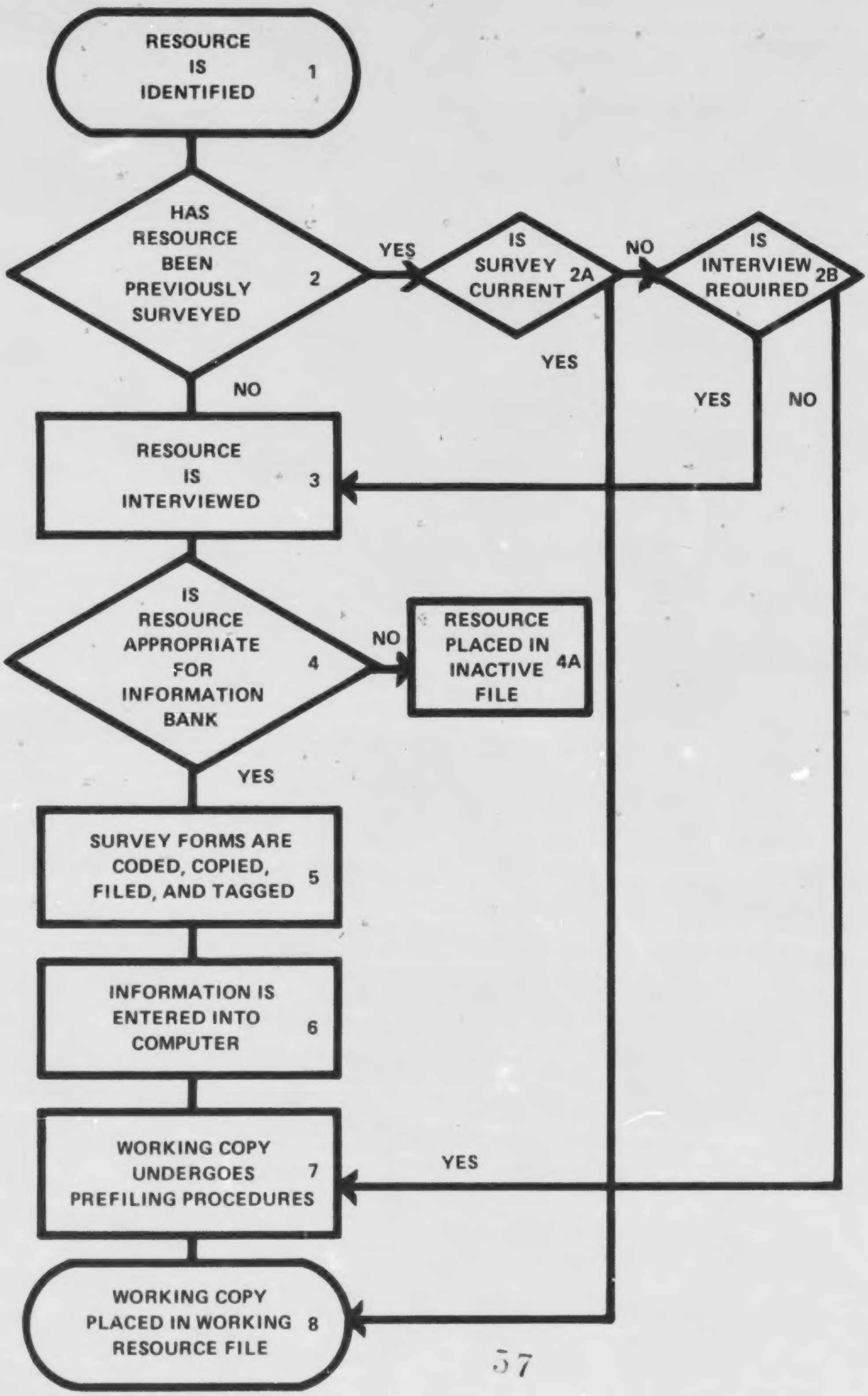
Step 13. Follow-up (One Year) - Are Services Appropriate?

The one-year follow-up serves the identical function as the six-month follow-up. If the services are appropriate, the referral proceeds to Step 14. If the services are not appropriate, the referral re-enters the process at Step 4 or Step 6.

Step 14. Inactive Status

If the six-month follow-up indicates that the services continue to be appropriate, the case is placed on inactive status. The case can be reactivated at any time at the request of the referring agent.

RESOURCE COMPONENT


RESOURCE IS IDENTIFIED 1
HAS RESOURCE BEEN PREVIOUSLY SURVEYED 2
YES
IS SURVEY CURRENT 2A
NO
IS INTERVIEW REQUIRED 2B
YES
NO
YES
NO
RESOURCE IS INTERVIEWED 3
IS RESOURCE APPROPRIATE FOR INFORMATION BANK 4
NO
RESOURCE PLACED IN INACTIVE FILE 4A
YES
SURVEY FORMS ARE CODED, COPIED, FILED, AND TAGGED 5
INFORMATION IS ENTERED INTO COMPUTER 6
WORKING COPY UNDERGOES PREFILING PROCEDURES 7
YES
WORKING COPY PLACED IN WORKING RESOURCE FILE 8

Resource Component

The resource component establishes and maintains a file of all resources that provide services throughout the state. The resource specialist manages the component, and is responsible for locating resources and collecting appropriate information on them so that the referral specialist can fashion the best possible match between available services and the needs of the handicapped child. The information on service providers is kept on file and is also entered into the computerized information bank mentioned earlier and described at the end of this chapter. That which is kept on file is recorded on survey forms which are included in Appendix F. The forms serve as the source from which information is entered into the computer by the data processor, who is responsible for storing and retrieving all computerized information. The surveying procedures followed by the resource specialist are outlined in a flow chart found on the opposite page and are explained in the following outline and narrative.

Step 1. Resource Is Identified

Resources entering the process at Step 1 are of two types: those which have not been surveyed previously and those which have been surveyed but whose files may need updating. Resources are initially located by studying public agency listings and directories compiled by community planning/information groups and through personal knowledge of local, regional, and state direction service center staff. Resource listings are routinely sent to the 20 education service centers within the state and to key local service providers so that their feedback can help identify additional resources and call attention to those files in need of updating. The identification of resource files in need of updating is done through computer printouts which list resources that have not been updated for a year. Additional identification occurs as the referral specialist identifies outdated survey information while working with clients.

Step 2. Has Resource Been Previously Surveyed?

After a resource is identified, the files are checked to determine if it has been surveyed.

IF YES, proceed to Step 2A
IF NO, proceed to Step 3

Step 2A. Is Survey Current?

Resources are surveyed annually to ensure the accuracy of the information being maintained in the resource file. If the resource has been surveyed within the last year, the survey proceeds to Step 8. If not, the survey proceeds to Step 2B.

Step 2B. Is Interview Required?

In certain situations the survey may require only minor changes which can be made without interviewing the resource agency. For instance, a referral specialist may contact a resource agency and discover a particular service is no longer provided. He or she would notify the resource specialist, who simply corrects the survey, initials and dates the corrections, and places the folder in a "to-be-entered" box for the data processor. In this situation the survey proceeds to Step 7.

If the survey needs to be updated, the resource specialist clips a note on the folder and places it in the "to-be-surveyed" box, in which case the survey proceeds to Step 3.

Step 3. Resource Is Interviewed

Before a newly identified resource is surveyed, the resource specialist must decide whether it meets the general criteria for inclusion in the computerized information bank. This decision is based on the type of services offered, target population for those services, and the current survey priorities established by the State Direction Service Center. After the resource has been surveyed, a final decision is made regarding its inclusion in the information bank.

The primary method of surveying resources is by telephone, using local lines when possible and the State and Federal Telecommunication System when necessary. Another method, used less frequently, is a person-to-person interview at the resource site, a method which provides more valid in-depth information but is more costly and time-consuming. Although many agencies are completely surveyed with one phone call, it is not uncommon for the resource specialist to interview several persons within an organization during the course of a single resource survey.

The person initially contacted at each resource agency is the executive director, and the resource specialist does not proceed with the survey until the director's approval is secured. Experience has shown that there is rarely any problem in securing this approval, although some agencies request to preview a copy of the completed survey form before the information is publicly disseminated. These initial contacts are an important step toward establishing working relationships with agencies because their staffs are often unfamiliar with the State Direction Service Center and the information and assistance it can provide them.

A form letter is sometimes mailed to an agency director to introduce the Center's services and to request printed information about the agency. Brochures and other agency literature seldom provide enough information to eliminate the need for a survey interview, but they sometimes reduce the time required for the survey by giving the resource specialist a preliminary picture of the resource and its services.

Step 4. Is Resource Appropriate for Information Bank?

Once the resource agency has been surveyed, the resource specialist decides whether the resource is appropriate for inclusion in the computerized information bank. To be included in the information bank a resource must provide one or more services as identified in Appendix I for one or more client types as identified in Appendix J. If the resource does not meet the necessary criteria, the survey is placed in an inactive file (Step 4A). If the resource does meet the criteria, the survey proceeds to Step 5.

Step 4A. Resource Placed in Inactive File

When a resource is considered inappropriate for inclusion, the name of the agency and a brief description of its services are placed in an inactive file. It is possible that in the future these services would be included in the computerized information bank.

Step 5. Survey Forms Are Coded, Copied, Filed, And Tagged

After the resource is interviewed, the resource specialist completes the survey form (See Appendix F) and makes one copy designated as working copy. The original form is placed in a permanent master file and is used only when the working copy is misplaced or extra copies need to be made. The master file eliminates the burden of resurveying a resource if the working copy is lost. A red tag is attached to the working copy, and it is placed in the "to-be-entered" box to await entry into the computer. The red tag identifies the survey as one which has yet to be entered and allows the direction service center staff members to use the survey without danger of its being misfiled or otherwise misplaced before computer entry.

Step 6. Information is Entered Into Computer

The data processor enters the information into the computer. At this point the agency information is available for systematic retrieval.

Step 7. Working Copy Undergoes Prefiling Procedures

The survey form is placed in a folder labeled with the name of the resource agency and its county and education service center (ESC). These folders comprise the working resource file. A standardized thank-you letter is sent to the respondent(s) at the resource agency (See Appendix K). This letter also outlines the services provided by the State Direction Service Center and encourages the resource agency to use the Center's services when possible. It also informs the agency that a resource specialist will update the information annually. A 3" X 5" index card containing the name and region number of the agency and its date of entry into the computer is typed, and a new date is entered on this card each time the information is updated. This card file serves as a quick reference index for data updating and reduces both user traffic at the resource file cabinet and maintenance-type retrievals from the computerized information bank. The red tag is removed from the survey forms.

Step 8. Working Copy Placed in Working Resource File

The resource folder is placed in an open standing file for use by State Direction Service Center staff members. The folders are grouped by ESC regions, and then by counties within regions. Within each county's section the folders are arranged alphabetically by name of agency.

These files are also cross-indexed via in-house computer printouts.

The user of a resource file writes his or her name and the date on a sign-out card found inside the folder and leaves this card in the files as a location marker. Users place the files in the "to-be-filed" box, where they are refiled daily by the component clerk, who marks out the user's name on the sign-out card.

Computerized Information Bank

The computerized information bank is comprised of two types of information: information pertaining to client records and information regarding service providers throughout the state.

Computerizing information on service providers makes possible a unique approach in providing information on resources for handicapped children. When carefully organized and disseminated, computer printouts can communicate clearly and effectively the same information as printed resource directories, while overcoming many of their traditional problems. One of these problems has been updating the information as services change in availability, cost, eligibility, and other key features. Once these changes are entered into the computerized information bank they are incorporated immediately in subsequent printouts without having to suffer the delays and expense of reprinting pages in a directory. Another difficulty inherent in printed directories is that of indexing. Even the simplest cross-indexing systems require printing multiple listings for the same resource. With a statewide information bank, such a directory can quickly become too large and unwieldy to be useful. The computer affords a variety of indexing options and allows the State Direction Service Center staff members to target individual information requests in terms of specified services, handicaps, and geographic locations. This targeting procedure yields output which is tailored to meet the particular needs of the user.

The primary consumers of the computerized information bank are State Direction Service Center staff members and the professionals within the education service centers who function as regional-level case managers for direction service referrals. The direction service has responded to information requests from other public and private agencies whenever budget and caseload factors have allowed. Some information requests are provided by telephone, and others result in a retrieval from the information bank. Whenever a computer printout is provided to a referring agent, it is accompanied by an orientation packet to acquaint the recipient with the organization of the information and to help him or her make the most effective use of it. Each computer information package mailed is followed by a letter requesting the recipient to complete an enclosed evaluation form (see Appendix B) and return it to the State Direction Service Center. This form provides feedback on the usefulness and accuracy of the information.

The Center shares time on the University of Texas computer and has purchased its own remote terminal unit. Entry of resource agencies is done via a feature which reproduces the Level I and II survey forms on a cathode ray tube. This allows the data processor to check off the desired information for a given page of the form, thereby minimizing time spent on data entry and reducing the opportunity for typographical or other data string generation errors. All data entry and output requests are submitted interactively by telephone so that syntactical mistakes or other errors can be found and corrected immediately.

This chapter has described the processes by which both the referral and resource components function. Also, this chapter has briefly discussed the computerized information bank, which is a support system to both components. The chapter which follows describes the computerized information bank in detail and will provide the reader with the major information elements of this system.

Chapter 4

THE RESOURCE INFORMATION BANK

THE RESOURCE INFORMATION BANK

During the three years of its operation the State Direction Service Center developed an information bank to provide its staff and clients with comprehensive, up-to-date information on service providers throughout the state of Texas. The total system has emerged in a series of stages as the information needs of its users have changed over the years. In the development of any direction service center, it is important to anticipate such changes and design the information bank so it can be revised as necessary.

The survey forms developed by the State Direction Service Center (See Appendix F) are used to document the services available through each agency (resource) listed in the information bank. The forms serve a dual function. A completed set of forms comprises the working file on each agency and is also the source for computer entry, requiring no intermediate data cards or coding sheets. The following section defines the key terms used in the forms and provides an introduction to the structure and organization of the resource files.

Resource Files

Each service provided by an agency is classified into one of three modes of delivery: direct, subcontracted, or support. A direct service is one which an agency is primarily set up to deliver. The State Direction Service Center assumes that, unless the service is filled to capacity, any client meeting all eligibility criteria can be successfully referred to an agency for one of its direct services. When an agency chooses to provide direct services which are beyond the scope of its staff or facilities, it may subcontract with another local agency to provide the desired service. For example, community MHMR centers often subcontract for a number of beds in a local hospital to handle clients needing inpatient services. They accomplish this on a fee-per-service basis in which the MHMR center pays the hospital for each MHMR client served. The Center considers a service subcontracted only if it is delivered *directly*, i.e., the client who qualifies will receive the service on a fee-per-service basis through the agency being surveyed. Agencies often provide additional services which are intended only to *support* their direct services. For example, a mental health clinic offers psychological counseling as a direct service for emotionally disturbed clients. The clinic may also own a bus to assist those outpatients who cannot provide their own transportation to and from the clinic. In this situation the bus transportation constitutes a service offered in *support* of the psychological counseling. Clients are provided transportation to make it possible for them to benefit from the direct service. Usually an agency will not accept a referral for a support service alone; the client's eligibility for a support service is dependent upon his or her participation in a direct service.

A Level I survey form contains only items of information pertaining to the agency as a whole (e.g., address, executive director), and lists each service offered. A Level II form is completed on each *direct* (or subcontracted) service listed on the Level I form and includes items specific to each service (e.g., fees, eligibility criteria, support services). Thus, a complete resource file on an agency consists of a Level I form containing general information on the entire agency plus a Level II form on each direct service offered.

Most items in both the Level I and II survey forms are entered into the computer and are designated as *storage* information. The remainder is termed *anecdotal* information and is kept on file and updated with the rest of the survey, although it is not entered into the computer. On the Level I form, for example, all items following "Direct Affiliation" are anecdotal, as are all items on page 3 of the Level II form. The decision whether to store an item in the computer or to maintain it anecdotally is based on the degree to which the referral specialists find the item useful and the frequency with which the item is retrieved from the information bank. In the next section each item contained in the Level I and II survey forms is discussed and, where necessary, the rationale for its inclusion is explained. Details are also given concerning how these items are organized and integrated in the information bank. The items which are entered into the computer are indicated by the word "storage" in parentheses following the item. Those items not entered into the computer are indicated by the word "anecdotal" in parentheses.

Level I Form

The top line of the Level I form consists of three items which assist in the maintenance of the information bank. Spaces are provided for the date the survey was taken, the date it was entered into the computer, and the name of the resource specialist who completed the survey.

Identifying Information

1. Name (storage)

2. Address (storage)

3. City (storage)

4. Zip (storage)

5. ESC Region Number (storage)

6. County of Location (storage)

7. County Catchment Area (storage)--counties which comprise an official geographic area for providing services. Storing the information in this manner allows printouts to be generated which list all services for which residents of a county are eligible, including services offered by resources not actually located in that county.

8. Telephone Number (storage)

9. Auspices (storage)--defines whether an agency is public, private (nonprofit), or proprietary (profit-making).

10. Direct Affiliation (storage)--identifies whether the resource is a subsidiary of one of the major public agencies whose acronyms appear on the form.

11. Executive Director (anecdotal)

12. Accreditation (anecdotal)--describes any accreditation, license, or certification granted by governmental or professional organizations.

13. Special Referral Procedures (anecdotal)--procedures or documents required to refer a client to the agency (i.e., some agencies will only accept referrals from physicians).

Service Classification (anecdotal)

This grid represents the classification system developed by the staff members of and consultants to the State Direction Service Center. The system classifies services into 13 categories (all capital letters) and 45 subcategories (lower case letters within each category). A definition of each subcategory of services can be found in Appendix I. The list of service classifications was not designed to cover all possible services to handicapped individuals, but instead it reflects the spectrum of services which have proven most beneficial to the variety of clients served by the State Direction Service Center.

In order to understand this system properly it is necessary to distinguish between the terms "program" and "service." Agencies typically describe their operations in terms of the programs they have developed to meet the needs of their clients. However, the type and number of actual services provided through an agency's programs will vary as a function of how the agency chooses to respond to those needs. A program may deliver only a single service or it may include an entire package of services, depending upon the objectives of the agency.

The resource specialist interviews an agency's staff members to obtain the program information and then translates this information into terms of the categories (all capital letters) and subcategories (lower case letters) of services listed in the grid. Each service provided by the agency is checked in the proper column to indicate whether its mode of delivery is direct, subcontracted, or supportive. Fitting the information into this standardized framework creates an information bank which offers consistent, integrated definitions for a variety of consumers. One who is familiar with the system can analyze a referral in terms of what generic services will be necessary to meet the client's needs.

When the resource specialist surveys a resource agency, there are three possible relationships between the content of the program and the direct services provided.

1. There may be a one-to-one correspondence between program and service:

   1 Program = 1 Direct Service

   For example, an infant stimulation program focusing on developmentally delayed infants 0-3 years of age would be entered as category: EDUCATION; subcategory: infant development.

2. The agency may offer several different programs, each of which offers the same subcategory of direct service:

   Program A

   Program B = 1 Direct Service

   Program C

   For example, a residential treatment facility might have three different programs, each housed in a separate dormitory and each focusing on a different type of handicapping condition. The direct service provided by these three programs will be represented on the grid by the single category: RESIDENTIAL; subcategory: treatment. The Level II survey will provide the referral specialist with the necessary information about each of the three individual programs.

3. A single program may be organized so that more than one direct service is delivered through it:

   = Direct Service A

   1 Program = Direct Service B

   Direct Service C

For example, an interdisciplinary diagnostic team may directly provide three different subcategories of service (educational, psychological, medical) within the diagnosis category. In this case, the single program will be represented by three separate direct service entries in the information bank, one for each of the three subcategories of service. Each entry is accompanied by complete Level II information, including any support services.

All services (direct, subcontracted, and support) are listed on the Level I classification grid. The information in this grid is not entered into the computer; instead, it serves as a table of contents for the subsequent Level II surveys in the agency's file.

Level II Form

While the Level I survey is a set of information concerning the resource agency as a whole, a Level II survey is specific to one service provided by that agency. A Level II survey is completed on each direct or subcontracted service provided by an agency.

Service Classification Grid (storage)

The service classification grid on the Level II form is identical to the one on the Level I form, but it identifies the specific direct or subcontracted service to which that Level II survey pertains. Any services available in support of that service are also indicated. The service classifications checked on this grid are entered into the computer, along with all other storage information from the Level II survey.

Special Modes (storage)

1. Mobile--indicates that the service can be made available to clients in their homes or at a compromise location.

2. Emergency--indicates that the agency will suspend normal preliminary information-gathering procedures in an emergency and provide the service to the client immediately.

Fee Information (storage)

1. Are Services Free to Client?--The service may be free under certain conditions or for clients meeting certain third-party funding criteria. The resource specialist provides a brief explanation of these conditions in the space labeled "Describe"; this is maintained as anecdotal information.

2. Maximum Fee Per Service Unit--If fees for this service are set on a sliding scale, this figure is the upper limit of that scale. If there is no sliding fee scale, the figure represents the current flat fee rate.

3. Sliding Fee Scale?--This item indicates whether the resource will adjust its fees according to the family's income level.

Duration of Service (storage)

The terms listed here (within 48 hours, less than one month, greater than one month) refer to the time span between the initial referral for service and the point at which the client actually begins to receive the service.

Type of Client Served (storage)

1. Client Type--This column lists 20 client types by handicapping conditions for which resources are surveyed and information is stored in the information bank. This list has been revised and modified throughout the history of the State Direction Service Center based on the type and frequency of referrals received by the Center. Some of these conditions are actually subsets of others (e.g., Autistic: Emotionally Disturbed), and some fall outside the common definition of "handicap" (e.g., Children In Need of Supervision, Delinquent), but they are included separately because of special problems which arise in locating appropriate services for children with these conditions. A definition of each handicapping condition is found in Appendix J. Check marks in the left margin of the column indicate the type(s) of client to which the service is primarily offered. Thus, this grid identifies the target population for the service

within this list of handicaps. Often agencies will provide services to persons with secondary handicaps if the target handicap is primary. These secondary handicaps are not identified on this grid, but they are explained in anecdotal form on page 3 of the Level II form.

2. Age, Sex, and Other Eligibility--To the right of each handicapping condition a space is provided which affords users of the information bank a precise description of the target population. Each primary handicapping condition can be qualified in three ways: age ranges served, sex of client, and a brief statement of any other specific requirements which must be satisfied if the client is to be served.

   An example of a specific requirement is that there are no architectural barriers. If a service is not accessible to persons in wheelchairs, then the eligibility space can be used to indicate that all clients must be ambulatory.

Program Information

All the items on this page pertain to the programs as they are organized and labeled by the agency. The preceding items in the Level II survey are concerned with a service as it is defined within the information bank, and the information is in a form which lends itself to computer entry. The program information deals in more detail with the method by which the service is delivered. In addition, not storing this information in the computer allows for narrative descriptions and comments on the programs which provide the referral specialist with in-depth information. This type of information is valuable after an initial screening of possible resources is completed.

1. Name of Program--This allows for entry of individividual program names which are different from the name of the agency and/or name of the service entered on the classification grid.

2. Name and Title of Program Director

3. Intake Phone Number

4. Address

5. Brief Description of Service--A narrative description of features of the program not specified elsewhere.

6. Average Duration of Program--This helps the referral specialist determine appropriate times for follow-up and reprogramming.

7. Hours and Days of Operation.

8. Staff--A listing of the number, types, and qualifications of all staff members providing the direct service to clients. This gives an approximate staff-to-client ratio and one index of the quality of service being offered.

9. Provide direct service for non-English-speaking child?--This item specifies which staff member can provide this service and in what language. Included here are staff members who are proficient in sign language.

10. Legal limitations to certain income levels?

11. Legal limits to certain geographic areas?--This describes the service area in terms other than a set of counties (e.g., coastal bend area, city of Austin).

12. Capacity--The maximum number of clients it is possible for the agency to serve at any one time.

13. How a referral is made if different from parent organization--If there are referral procedures specific to this particular program, they can be entered here as a supplement to the referral information included in the Level I survey.

14. Respondent--Name of the person providing the resource specialist with information regarding this program.

15. Comments.

Information Bank Retrieval

State Direction Service Center staff members make use of the information bank either by examining folders from the standing resource file or by retrieving information from the computer. One can selectively "browse" through the information bank via a cathode ray tube (CRT) terminal at the Center or by requesting printouts, which are then kept on file and are disseminated to regional or local case managers. Because the State Direction Service Center must share time on a large university computer, immediate interactive retrievals from the information bank are sometimes limited. Consequently, the use of printouts in combination with the standing file has proven to be the best method to gain access to the information.

Printouts are obtained by request via the CRT terminal. Except in the case of unusually large requests, the maximum turnaround time is 24 hours. The printouts are picked up from the university computer center and the "day file" page (showing central processing time and total cost) is filed. The printout is then delivered to the staff member making the request.

The Information Bank Request Form (See Appendix L) allows the staff members to communicate precisely the type of information needed and to specify how the information is to be organized in the printout. This form has two parts which divide the process of retrieving information from the information bank into two sequential decisions, represented on the form by Parts 1 and 2 respectively.

Part 1 (Decision 1)

This decision involves choosing the qualifying descriptors. These descriptors allow the computer to retrieve only those resources which meet the requirements of the individual request; for example, resources which provide a particular service, resources which serve children with a certain type of handicap, resources that are located in a specified area, etc. These descriptors may be used singly or in combination to create a customized printout.

Part 1 of the request form lists in the left-hand column (Type of Information) the 21 items of information about each resource which are stored in the computer. Thirteen of these 21 items have corresponding blank spaces in the right-hand column (Qualifying Descriptors). These 13 items are called "key" items and cause the computer to retrieve selectively. For example, item #3, "City," is a key item. This means that the resources in a particular city can be retrieved by writing the name of that city in the blank space in the Qualifying Descriptors column. If "Houston" is entered as a qualifying descriptor for "City," then only resources located in Houston will appear on the printout. If, in addition, item #11, "Service Category," is qualified by one of the general services categories (for example, Residential), the computer will only retrieve resources which are located in Houston and provide a residential service.

The request may be further qualified in terms of any or all of the 13 key items. For example, the user may only want information on resources which are located in Dallas and provide special education services to children with cerebral palsy. These retrieval instructions are indicated on the form by qualifying key items as follows:

3. City - Dallas
11. Service Category - Education
12. Service Subcategory - Special
20. Handicap - Cerebral Palsy

If qualifying descriptors are entered in this way, no resources will be retrieved which fail to meet these basic requirements. The eight non-key items cannot be used for qualifying the retrieval, but they can appear on the printout, as explained in Part 2. If no qualifying descriptors are entered, the computer will retrieve information on all resources in the information bank.

Many state agencies organize their services according to target regions made up of a county or set of counties (see Level I survey item "County Catchment"), but these regional boundaries vary widely from one agency to another. The computer retrieval system contains a special feature which can help to reduce confusion when a resource specialist is sorting through the gaps and overlaps affecting a client's eligibility for various state hospitals, schools, and welfare programs. To activate this feature the user qualifies item #10 "County Catchment" on the Information Bank Request Form with names of a specific group of counties. The resource data string appearing on the printout will then be grouped according to county. When the printout is to be grouped according to county the computer will include within each county's listings all services for which residents of that county are eligible. Thus, services listed for a particular county may actually be offered by a resource located in a neighboring county.

Part 2 (Decision 2)

The second decision involves determining the other items of information needed for the resources the computer has been instructed to retrieve. In the latter example above, each resource appearing on the printout will be located in Dallas and will provide special education to children diagnosed as cerebral palsied. The user must indicate which of the 21 stored items he or she wishes to have printed out on each of the resources that satisfy the qualifying descriptors. By analyzing the requests over a period of time, a series of 12 "data strings" have been developed which represent the most commonly requested sets of items. Each of these data strings is more fully explained in Appendix M. The user simply checks the string(s) he or she desires, or selects an independent set of items and lists them in the blanks beside "OTHER." Any of the 21 storage items can be requested in Part 2 as part of the data string. Some of the preset strings contain identical items but are organized differently (e.g., "HANDICAPS" and "CATEGORIES," "FEE I" and "FEE II"). This facilitates their use in combination with other data strings and affords the user additional flexibility in approaching the referral problem.

This chapter has presented the key features of the resource information bank. From this discussion it is apparent that the resource specialist must develop a set of specialized skills in order to gather information accurately and efficiently from service providers, to code it onto the survey forms, and retrieve it from the computer and standing files. The next chapter describes the training provided to resource specialists and presents the materials used in that training.

Chapter 5

TRAINING ACTIVITIES FOR THE RESOURCE SPECIALIST

TRAINING ACTIVITIES FOR THE RESOURCE SPECIALIST

As noted in Chapter 1, the Texas Education Agency funded each of the 20 education service centers (ESCs) to develop its own regional direction service center. The Agency provided guidelines for the development and operation of these regional projects in the Request for Proposals (RFP) distributed to the ESCs. Certain features of the model, particularly those associated with the resource information bank, were highly detailed in the RFP so as to keep these procedures uniform among the centers. Other features of the guidelines were stated in more flexible terms to enable each ESC to adapt the model to meet the needs of its own region.

The RFP asked each regional center to submit copies of its resource survey information on standardized forms to the State Direction Service Center (SDSC) for entry into the statewide information bank. Each region could obtain printouts from the information bank by calling the toll-free number at the state center and placing its request. The RFP specified the staffing patterns of the centers based on demographic factors within each region and stated that the SDSC would be responsible for training the ESCs' professional staff members in the roles of the resource and referral specialists.

The SDSC trained these persons at a series of workshops beginning in the fall of 1977. Specialized training was offered in the functions and procedures of both the resource and referral components. Resource specialists were trained to survey agencies, record the information on standardized forms, and use the statewide information bank. Referral specialists were trained to conduct comprehensive needs assessments for clients, identify services to meet those needs, coordinate arrangements for the client to receive the services, and perform other case management functions. Both groups attended awareness-level presentations with representatives from major service providers, and each center was given technical assistance as needed regarding current client cases and surveying resource agencies.

This chapter presents all the materials developed by the SDSC to train resource specialists, excluding those incorporated into previous chapters. These materials are not intended to function as a self-guided training package for organizations developing direction service centers; however, they do illustrate the issues and problems associated with the development of the computerized information bank at the Texas SDSC. The specific training activities can be modified and adapted by groups interested in implementing similar direction service operations.

The goal of resource specialist training is to provide each participant with the expertise to gather the appropriate information from resources and to represent it accurately on the survey forms. The training begins with a presentation of general resource identification procedures as outlined in Chapter 3. After a discussion of general procedures, the participants are introduced to the content and format of the Level I and II survey forms as presented in Chapter 4 and in Appendix F. This stage of training explains the rationale for including the items on the survey forms and details how these items are organized and integrated to form the information bank. The focus of training then moves to the Procedural Guide found later in this chapter. The guide reveals the specific procedures followed in accounting for the services an agency provides and functions as the primary reference tool for subsequent stages of training.

Next the participant is asked to take part in exercises which focus on specific problems that may arise when one is interviewing agency respondents and coding the survey forms. After the participant completes an exercise, the trainer initiates a short discussion centering on the issues raised by that exercise.

The participants then read edited transcripts of two telephone interviews and complete survey forms for each agency involved. The first transcript is simple; the second is more complex, requiring the resource specialist to make more sophisticated decisions regarding programs, services, and types of children served. These transcripts introduce information from the interview in a form that closely approximates the form to which each referral specialist will be exposed in actual practice, but the material is presented in a written format so that the participant can refer to it as he or she fills out the forms. Each of the two transcript activities is done separately, and a discussion follows each which analyzes the survey item by item. Both transcripts are included in this chapter, along with the completed survey forms. Each response in the transcript has been assigned an identification number, and each item in the survey is referenced with an identification number corresponding to a response or set of responses in the transcript. These references allow the participants to analyze the process by which the information from the agency respondent is translated into the language of the survey forms. Certain items and aspects of the survey are discussed in detail in a narrative section which follows each set of forms.

The next stage of the training is an actual demonstration survey. The trainer interviews an agency respondent by telephone while the participants listen on extension lines and take notes independently. After the call each participant fills out the survey forms from his/her own notes. The completed forms are compared and discussed in group session.

The final stage of training requires each participant to conduct a telephone interview while the trainer and other participants listen on extensions. After each interview everyone again independently completes a set of survey forms, which are compared and discussed.

In the first few days after the training, each resource specialist is asked to conduct surveys of two different types of agencies, submit the completed forms to the SDSC, and then wait for feedback from the state-level resource coordinator before proceeding with further surveys. This procedure allows the coordinator to discover any residual areas of confusion prior to the entry of a large number of surveys.

This chapter presents material specific to the resource specialist training activities. Chapter 6 contains the referral specialist training activities. As was the case with chapter 5, the training materials for the referral specialist are not intended to be a self-contained training package because they do require a trainer to present the materials and guide the discussions.

Procedural Guide

The types of services that resources provide vary greatly. There is also little uniformity in the manner in which these services are made available to the public. For example, two resources provide diagnostic screening services for deaf children; however, one requires the client to come to the center but the other will perform the service in a mobile unit at the client's house. The SDSC has learned from experience that the problems involved in recording the unique features of each agency for efficient retrieval from the information bank (whether computerized or manual) can be minimized by using a standardized set of guidelines that govern the collection of the resource information and its recording onto the survey forms. The SDSC developed this Procedural Guide to expand the explanation of the information bank given in Chapter 4 and to provide detailed instructions for completing the survey forms.

Level I Form

Data Base Maintenance Information - These items are completed on each Level I survey.

1. Date Taken - Enter the date the survey is completed.

2. Date Entered - Leave this item blank. The data processor will enter the date on which the information is fed into the computer.

3. Surveyed By - Write your first initial and last name here.

Determining the Number of Level I Forms

The resource specialist must decide how many Level I forms need to be completed for a given resource agency. When a resource agency provides services at several different addresses, complete a separate Level I form for each address which performs an intake function. Level II forms will then be attached to this Level I to cover all services which receive their referrals through this intake office. For example, an agency may operate halfway houses at various locations in a large city, but receive all referrals for these programs through a single central office. In this situation a Level I form is completed for the central intake office, and Level II forms are attached to cover the services delivered through the halfway house programs.

All services provided by an agency should be documented in the survey except those services which are beyond the scope of this information bank. Services are considered outside this scope if they:

> Do not fall within the definitions of categories and subcategories of service listed in Appendix I (e.g., clerical or administrative services).
>
> Are open only to clients outside the SDSC's target population.

Complete a single Level I survey for all subcontracted direct services (using the address of the main office) and attach a separate Level II survey for each subcontracted service.

Identifying Information

1. Name - The name of the agency is vital for retrieving information from the computer and/or the vertical resource files. Several guidelines for choosing the exact wording of agency names are presented in this section. They are designed to ensure that each agency recorded on a Level I survey has a unique name and that parent agencies and their satellites (each represented by a separate Level I) will be grouped together when resource names are listed alphabetically, such as in a computer printout.

Guidelines

Do not begin a name with "The," because this will group resources alphabetically in the letter "T."

The only abbreviations which may be used in an agency name are those which appear under "Direct Affiliation" on the Level I form. These acronyms should be used whenever possible but all other names should be spelled out.

Parent organizations and their satellites are grouped together alphabetically by adhering to the following procedures:

When the parent agency is a statewide organization with satellites in several different cities, enter the name of the parent agency first and then add a name which identifies the satellite.

Example

Nueces County Mental Health and Mental Retardation (MHMR) is headquartered at 1630 South Brownlee Street, Corpus Christi, Texas. MHMR is the statewide parent agency in this case and the Level I name should read:

"MHMR - Nueces County"

When a satellite has sub-satellites of its own, complete a Level I form for each facility through which intake services are delivered. The name of each of these sub-satellites should be an extension of the parent agency's name.

Example

Nueces County Mental Health and Mental Retardation (MHMR) operates an Alcoholism Rehabilitation Center at 615 Oliver Street. The Level I name should read:

"MHMR - Nueces County - Alcoholism
Rehabilitation Center"

In this example there is only one program at 615 Oliver; thus, the name is apparent.

When several programs are operated at the same address, it can be more difficult to choose a logical name.

Example

> Nueces County MHMR operates a day care center and a guidance center for emotionally disturbed children at 3455 South Alameda. The name can be entered:
>
> "MHMR-Nueces County-Child
> Mental Health"
>
> An alternate name could be:
>
> "MHMR-Nueces County-Children's
> Center"

In this example, the choice of a name was guided by determining a meaningful common denominator among all of the services delivered through that facility. Sometimes, however, the programs at a given address bear little content similarity.

Example

> At 823 Furman Street, Nueces County MHMR operates an activity center for retarded persons, an outpatient counseling program, plus a diagnostic program for disturbed children. The Level I could be titled:
>
> "MHMR-Nueces County-Furman
> Street Office"

When a sub-satellite office is located in a city other than the satellite headquarters, use the city name as part of the sub-satellite's name.

Example

> Nueces County MHMR (headquartered in Corpus Christi) operates an outreach clinic at 550 North Fourth Street in Robstown, Texas. This resource's name can be entered as:
>
> "MHMR-Nueces County-
> Robstown Outreach"

The same format of "parent agency - satellite-sub-satellite" is used for names of all large organizations with local offices in several cities. Two examples follow.

Example

The Texas Rehabilitation Commission district office in Dallas is entered as:

"TRC - Dallas"

One of its sub-satellites is entered as:

"TRC - Dallas - West
District Office"

Example

The Easter Seal office in Longview is entered as:

"Easter Seal - Longview"

There is considerable leeway when choosing some Level I names. These guidelines can help the resource specialist enter an appropriate name for each agency, but careful judgment must be used so that the name facilitates convenient retrieval from the information bank.

2. Address - Enter both the street and mailing address if these are different.

3. City

4. Zip Code

5. ESC Region Number

6. County of Location

7. County Catchment Area - If the agency is officially set up to serve residents of a specified group of counties (e.g., MH/MR service area), list all these counties here, including county of location. If its service area is a city or local school

district or anything other than a specific county or group of counties, leave this space blank. When an agency accepts children from all over the state, and in your opinion it comprises a significant resource for persons in other geographic areas, enter the word "statewide" in the space for county catchment area. This allows an exclusive retrieval to be made of important resources of which local case managers may not be aware.

8. Telephone - Enter the agency's main administrative number. Telephone numbers for specific service components will be entered on the appropriate Level II survey.

9. Auspices - Check:

"Public" if the agency is sponsored and supervised by city, county, state, or federal government.

"Private" if the agency is operated by a nonprofit service organization.

"Proprietary" if the agency is operated for profit.

10. Direct Affiliation - Check the appropriate blank if the resource is a subsidiary of one of the public agencies whose names and acronyms appear here:

Texas Rehabilitation Commission	(TRC)
Texas Youth Council	(TYC)
Mental Health/Mental Retardation	(MHMR)
Department of Human Resources	(DHnR)
State Commission for the Blind	(SCB)
Department of Community Affairs	(DCA)
Department of Health Resources	(DHthR)
Social Security Administration	(SSA)
Veterans Administration	(VA)
Texas Education Agency	(TEA)

11. Executive Director - Enter the name and official title of the agency's executive director.

12. Accreditation - Describe any accreditation or license granted by federal, state, or local government agencies. Include any certification or official approval of services granted by professional organizations.

13. Special Referral Procedures - Use this space to provide a narrative description of any special procedure or documentation required to refer a client to the agency; for example, some agencies will only accept referrals from M.D.'s.

Service Classification Grid

As previously described, the service classification grid appears on both the Level I and II forms but has a separate function on each form. The Level I grid functions as an index to the total array of services provided by the resource. From the program descriptions given by the agency respondent, check each service the agency provides. If a service is offered in both direct and supportive modes, both modes may be checked on the Level I grid. On the Level II grid all three of these modes are mutually exclusive, and only one mode may be checked for any service. The reason for this difference is that no information is entered into the computer directly from the Level I grid. It serves only as a quick visual index of the services offered by an agency and as such is a valuable part of the open file on any resource. The Level II grid contains the information which is stored in the computer and each service must be classified discretely.

When classifying a program within a particular category and subcategory, attention should be focused on the content and goals of the program rather than on the name of the program. Programs with identical names may differ widely in the services that are actually offered (e.g., halfway houses). The definitions of each category and subcategory of service are found in Appendix I.

Level II Form

Service Classification Grid

Complete Level II information is collected and entered into the computer for each service offered in either direct or subcontracted modes. It is important to remember that within this system a subcontracted service is a direct service which the agency pays someone else to provide. The direct or subcontracted service to which the Level II survey pertains should be checked on the service classification grid, along with all services provided in support of that service. A service may not be checked in more than one mode on the same Level II grid.

In theory, the resource specialist should complete a separate Level II survey form for each direct and subcontracted service offered by an agency. However, in actual practice it often happens that all Level II storage information (fees, support services, type of client served, etc.) is identical for more than one of the agency's direct or subcontracted services. When this occurs, the resource specialist checks as many direct or subcontracted services on one Level II form as have exactly the same Level II storage information. The Level II survey will be entered into the computer separately for each direct service checked, but the resource specialist saves time and paper.

For example, a mental health clinic offers the following direct services:

Direct Service	Child Type	Age	Fee Structure	Support Services
1. Counseling/ Psychological	ED	12+	Sliding Scale	None
2. Counseling/ Parent/Family	ED	0-22	Sliding Scale	None
3. Diagnosis/ Psychological	ED	0-22	$40/Evaluation	None
4. Therapy/ Psychotherapy	ED	12+	Sliding Scale	None

If one assumes that all storage information not mentioned above is identical (e.g., service wait), these four services can be covered in three Level II forms. The first and fourth services can be combined on one Level II (same eligibility restrictions and same fee structure) form. However, the second service has a different age restriction, and the third service has a different fee structure. Because of these differences, services must be covered in separate Level II forms. When deciding whether to combine direct services on a single Level II, it is important to remember that each direct service checked on the same Level II must have the same support services; in other words, if a service is checked as "support," it must be an available support service to every "direct" or "subcontracted" service checked on that Level II grid. For example:

Direct Service	Child Type	Age	Fee Structure	Support Service
Education/ Special	Hearing Impaired	6+	Free	Speech Therapy
Education/ Parent	Hearing Impaired	6+	Free	None

Separate Level II forms are needed for these two direct services. Child type, eligibility, and fee structure are identical, but one direct service carries a support service and the other does not. If both of these services are combined on one Level II form, the implication is that speech therapy is a support service to both special education and parent education.

When two or more direct services are combined on a single Level II form, the resource specialist may choose to provide individual anecdotal information for each service by attaching additional page 3's of the Level II form.

The situation occasionally arises in which a service is offered on both a direct and support basis. For example, some private educational institutions not only provide speech therapy in support of their direct special education service, but also offer speech therapy directly to children from public schools. In this example the Level II survey for the direct special education service lists speech therapy as a support service, and a separate Level II survey is completed on speech therapy as a direct service.

Special Modes

If the service is provided on either a mobile or emergency basis (as defined previously), place a check mark in the appropriate space. If neither of these special modes is appropriate, leave these spaces blank.

Fee Information

1. Are services free to client? Choose one of the three options to indicate whether the answer to this question is:

   Yes always.

   No.

   Sometimes - if this option is checked, write a brief explanation in the space labeled "Describe conditions for lowered fees or free service..."

2. Maximum fee per service unit? - Enter the maximum amount that might be charged to a client per service unit (e.g., per hour, per month, per evaluation, etc.). If fees are set on a sliding scale, enter the limit of this scale.

3. Sliding fee scale? - Check either "yes" or "no" depending upon whether such a scale exists for this service.

Service Wait

Choose one of the three options to describe the routine time lapse between a client's application for service and the actual receipt of service:

Within 48 hours
Less than one month
More than one month

Duration of Service

Check one of these two options to indicate whether the duration of service is limited to a specific time span for all clients.

Limited
Unlimited

Primary Client Type Served

1. Handicapping Conditions - Check only those handicaps which constitute a primary target population for the service. Secondary handicaps should not be checked on this page, but they may be described on page 3 of the Level II form.
2. Eligibility - The 50 spaces to the right of each handicapping condition may be used to detail each type of client served in terms of:

> Age Restrictions - The first term is the age range within which a client is eligible to receive services from an agency. The age range is entered in years, for example, 12-18 or 1 1/2 - 3. If an agency serves anyone 16 years or older, enter "16+"; if 16 or younger, enter "0-16." If two different, noncontinuous age ranges are served by programs within the same service subcategory, enter both age ranges, leaving one blank space between them. For example, if an institution offers one class of remedial education to L/LD children 6-9 years and another class to L/LD adolescents 13-16 years, the ages would be entered on the L/LD line in the grid as: "6-9, 13-16." If there are no age restrictions, nothing is entered.

Sex of Client - This notes if a service is restricted to one sex or another, using the symbols "M" or "F." If there are no restrictions, nothing is entered.

Other Significant Eligibility Requirements - If necessary, the remainder of the spaces in the eligibility portion may be used to describe any specific eligibility requirements which must be met if the client is to be served. A list of requirements which frequently occur is included in Appendix N.

Program Information

All items on page 3 of the Level II survey are program specific. Maintaining this information in an anecdotal, noncomputerized fashion allows flexibility in the type of information available to the file user. If more than one program or service is being covered within a single Level II survey form, the resource specialist can choose to complete a separate page 3 for each program covered and attach the extra pages to the Level II survey. As previously mentioned, this option can also be exercised when more than one direct service with identical storage information is being entered with a single Level II form. The items on page 3 provide the referral specialist with an easily understood narrative description of individual programs, emphasizing details not specified elsewhere in the survey. Items 1-4 are used only if the program information differs from that of the agency.

1. Name of Program
2. Name and Title of Program Director
3. Service Component Telephone Number
4. Address
5. Brief Description of Program - This description should focus on the content of the programming and the environment in which it is delivered. Features of the program which are not covered elsewhere in the survey should be included here.
6. Hours and Days of Operation - Normal operating hours plus any special scheduling (summer hours, etc.).
7. Average Duration of Operation - Average stay of a client within the program.
8. Staff - Professional staff involved in delivering services to clients. This does not include support

staff (e.g., cooks, secretaries, etc.) or professionals employed in strictly adminsitrative positions (e.g., the director of a state hospital).

9. Provide Direct Service for Non-English-Speaking Child? - Include here only direct service staff (among those listed in item #8) who can provide this service. Also include any staff members who are proficient in sign language.
10. Legal limitations to certain income levels? - If this item applies, describe the limitations.
11. Legal limitations to certain geographic areas? - If there are limitations which are different from those entered in the Level I item "Catchment Area," these may be described here.
12. How many can be served at full capacity? - Maximum capacity of the program.
13. How a referral is made if different from parent organization? - Describe any referral procedures which differ from those entered in the Level I survey.
14. Respondent - Name of the contact person providing the information about this program.
15. Comments - Any details or commentary which would help the Direction Service Center staff make decisions concerning services from this agency.

Exercises 1, 2, and 3 focus the training on specific aspects of the survey process. After the participants complete each exercise independently, the trainer facilitates a group discussion of the issues raised by the exercise.

Exercise 1: Selecting Names for Resources

MHMR of Harris County is headquartered at 2501 Dunstan, Houston, Texas. However, its programs are available at many different locations. If referral intake is through an address other than that of the program, the address of the intake facility is in parentheses following the program name. How many Level I forms would you fill out to cover these programs? What names would you use?

Mental Retardation Screening and Referral Service
2501 Dunstan, Houston, Texas

Children's Outpatient Clinic (referral intake through
709 Shotwell)

7107 Marshall, Houston, Texas

Denver Harbor Mental Health Center
709 Shotwell, Houston, Texas

Bayshore Residence (Referral intake through 2501 Dunstan)
909 North Ashbel, Baytown, Texas

Inner City Infant-Parent Training Center
4401 Lovejoy, Houston, Texas

Extended Living Program (Referral intake through 709
Shotwell)
909 North Ashbel, Baytown, Texas

Village Infant-Parent Training Center
2501 Dunstan, Houston, Texas

Area I Recreation Center
4401 Lovejoy, Houston, Texas

Ripley Mental Health Center
4401 Lovejoy, Houston, Texas

MHMR of Harris County subcontracts for services with:

Grammercy House
4039 Grammercy, Houston, Texas

Harris County Center for the Retarded, Inc.
3550 West Dallas, Houston, Texas

Key to Exercise 1

Selecting Names for Resources

This group of programs can be organized into four Level I survey forms. By organizing the survey information in the manner shown here, all services indicated on each set of survey forms can be accessed through the address and phone entered on the Level I form. Note that constructing the names according to the instructions in the "Procedural Guide" yields Level I entries which will cluster in an alphabetical listing. It is also important to note that the number of Level II survey forms attached to each of these Level I forms will vary, depending upon the number and characteristics of the direct services delivered through these programs. Suggested names for the Level I surveys are listed below. The individual program names can be entered on page 3 of the Level II forms in each set of surveys.

1. MHMR - Harris County
   2501 Dunstan, Houston, Texas

   (a) Mental Retardation Screening and Referral Service
   (b) Bayshore Residence
   (c) Village Infant-Parent Training Center

2. MHMR-Harris County - Denver Harbor Mental Health Center
   709 Shotwell, Houston, Texas

   (a) Denver Harbor Mental Health Center
   (b) Children's Outpatient Clinic
   (c) Extended Living Program

3. MHMR - Harris County - Ripley Mental Health Center
   4401 Lovejoy, Houston, Texas

   (a) Ripley Mental Health Center
   (b) Inner City Infant-Parent Training Center
   (c) Area I Recreation Center

4. MHMR - Harris County - Subcontracted Services
   2501 Dunstan, Houston, Texas

   (a) Harris County Center for the Retarded, Inc.
   (b) Grammercy House

Exercise 2: Identifying Types of Clients

This is an excerpt from a survey interview. On the basis of the information given, identify the child types to be checked on page 2 of a Level II form.

I = Interviewer
R = Respondent

I: What types of children are eligible for your program?

R: Well, since we are in a rural area where there aren't many programs, we will take just about any mentally retarded child.

I: Will you take all levels of mental retardation - educable, trainable, and profound?

R: Well, usually the educable MRs wouldn't come to our program because our school district has classes for them.

I: So we shouldn't refer an EMR child, but we could refer a TMR or PMR?

R: Yes, we will take TMR and PMR.

I: Would you take an MR child who also has other handicaps? For instance, what if he is also cerebral palsied?

R: Oh, yes, several of our children are CP.

I: Let me pose a hypothetical case of a child who is definitely cerebral palsied but whose intellectual functioning is in the normal range. Would this child be appropriate for your program?

R: Not really, although I wouldn't want to be absolute about it. It would depend on what other services are available to the child as well as other factors of the individual case.

I: What about if he is also emotionally disturbed?

R: Well, he couldn't be violent. We couldn't have a child who might hurt himself or someone else. Also, we really don't have a large enough staff where we could spend time controlling emotional behavior.

I: How about if he has a visual or hearing impairment?

R: That would have to be a pretty slight impairment because our staff really isn't trained to work with blind or deaf children.

I: What about if he is orthopedically handicapped?

R: Yes, that is all right. We have had some really low level MR kids who are nonambulatory, and we have the physical set-up to provide our programming to physically handicapped MRs.

Key to Exercise 2

Identifying Types of Clients

As the procedural guide makes clear, the main function of the classification grid is to indicate the types of children for which the service is primarily intended. From the information obtained in the interview, the service appears set up to serve the trainable and profoundly mentally retarded (TMR & PMR). The information on acceptable secondary handicaps (cerebral palsy and orthopedic impairments) should be recorded in anecdotal form on page 3 of this Level II survey, along with the limitations on secondary emotional difficulties and vision/hearing.

Exercise 3: Classifying Services

Assign a category - subcategory classification to the services described in each of these examples. (Note: the information in these examples is insufficient to make decisions on modes of service.)

1. Our clients have mental health problems that aren't serious enough to require residential treatment, but they need more than just the usual outpatient services. They come Monday through Friday from 9 to 3 and we work on things such as socialization skills, group processes, assertiveness training, etc., through group activities.

2. We run a Big Brothers program. Men in the community volunteer their time to spend with a "Little Buddy." Little Buddies are children who don't have fathers living at home or who aren't living with their parents. Their Big Buddies try to help fill that gap, be a friend to the child. They might take the child to a movie or to the park. The idea is to spend time with the child and be an adult friend to him.

3. The goal of our school's program is to develop the child's maximum potential. Of course we aren't going to create Einsteins, but we can usually get our children to a point where they have the basic academic and social skills necessary to live independently.

4. We also have a school here, grades K through 12. We ask our patients to bring their public school records with them. Since our primary treatment program frequently requires the child to be in residence here for several months, we want to make sure he doesn't fall behind academically while he's here. The local ISD provides our teachers, and I think they do a good job of keeping the children up with the school work so they are on grade level when they return home.

5. Most of our boys have had problems in school. Usually the problems stem from motivation rather than a lack of intellectual ability. So in our education program we focus on specific academic

deficits within an environment that encourages improvements in their behavior and attitudes. We focus on getting each child to grade level -- getting them to where they have both the skills and the motivation necessary to succeed when they go home.

6. We are an orthopedic hospital. Our patients come from all over the country. Generally they stay about six months to a year and during that time they receive whatever forms of rehabilitation they need.

7. We run a wilderness camp for emotionally disturbed boys. We believe this is a valuable alternative to the traditional institutional setting. We don't do structured therapy in any formal sense. Rather, we use the processes involved in supervised group living in a fairly rugged physical environment to facilitate the learning of more constructive behavior patterns.

8. Our girls are here because they really have nowhere else to go. This is their home, and they may live here until they are 18 years old. We have four cottages, each housing six girls and houseparents. The girls go to public school in town. We don't do therapy or anything like that. If a girl needs any special help, we contact the local MHMR center.

9. We provide a home for 15 mentally retarded boys. For various reasons they cannot live at home. In most cases, their family just can't take care of them. Most of our boys have the potential to live independently when they reach adulthood. The younger boys go to special education classes at a public school; the older boys go to a vocational training center in town. We have a counselor on staff who works with the boys on living skills and vocational skills.

10. We are a project of the state hospital. We have a house which accommodates 10 children. Most of our children are in an emotional crisis, and we try to stabilize them so they can return home quickly and not be institutionalized. They stay with us an average of 30 days.

11. When we think a child is ready to leave our program he goes to our Hartford House for a six-month trial period. We have 12 children there at a time. The group at the house functions like a conventional family and the kids go to public school, participate in community activities, generally live in a normal environment. There are counselors on staff, and of course, if necessary, the children also have access to the staff and services at the state school. If a child can function satisfactorily at the Hartford House, then we consider him ready to return home.

Key to Exercise 3

Classifying Services

1. "Education - Basic Life Adjustment" This program is a good example of the "day treatment" approach utilized in many community mental health settings. The program is basically educational, although counseling is almost always offered as support in this type of service.

2. "Counseling - Paraprofessional/Volunteer"

3. "Education - Special" The clue to the subcategory classification of "special" is the school's intent to develop the "skills necessary to live independently." This brief statement supplies much information about the nature and level of the curriculum offered.

4. "Education - Regular" The educational program described here is obviously part of a residential treatment program.

5. "Education - Remedial"

6. "Residential - Treatment"

7. "Residential - Treatment" Even though this is a noninstitutional setting, the program still offers treatment in a residential environment.

8. "Residential - Care" This program is very similar to a halfway house, but provides no treatment. It is devoted to the provision of care.

9. "Residential - Halfway House" This service goes beyond the custodial care of its clients and also provides treatment-oriented programming.

10. "Residential - Halfway House" This program is an example of an alternative to entry into an institution.

11. "Residential - Halfway House" This program is classified the same as number 10, but is provided as an interim setting for clients exiting an institution.

Transcript I
Survey of McDonald School

1 RECEPTIONIST: McDonald School

2 SURVEYOR: Could I speak to someone about the services you offer for children?

3 RECEPTIONIST: I'll connect you with Mrs. McDonald.

4 MRS. McDONALD: This is Mrs. McDonald.

5 SURVEYOR: Hello, my name is ___________ with the Texas Learning Resource Center in Austin. Have you heard of our agency?

6 MRS. McDONALD: No, I don't believe I have.

7 SURVEYOR: We are an information and referral agency serving handicapped children throughout the state of Texas. We have a toll-free WATS number and anyone can call us when they are trying to locate a service for a handicapped child. We survey agencies throughout the state which provide services for children and put the information in a computerized information bank. When persons call looking for a service for a handicapped child, we try to match them up with an appropriate service in their geographic area.

8 MRS. McDONALD: I see, what is the name of your agency again?

9 SURVEYOR: The Texas Learning Resource Center.

10 MRS. McDONALD: That sounds like a good service. We're always getting referrals for children we can't handle and we don't know where to refer them.

11 SURVEYOR: Would you have some time right now for me to ask you some questions and get some information about your agency?

12 MRS. McDONALD: Yes, right now would be fine.

13 SURVEYOR: Could you give me the official name of your organization?

14 MRS. McDONALD: The McDonald School for Special Children.

15 SURVEYOR: And your address?

16 MRS. McDONALD: 108 South Oak Street, Houston, Texas.

17 SURVEYOR: And your phone number is 478-1256?

18 MRS. McDONALD: Yes.

19 SURVEYOR: What county are you in?

20 MRS. McDONALD: Harris

21 SURVEYOR: And do you provide services to anyone other than residents of Harris County?

22 MRS. McDONALD: We would but because of commuting most of our students are from Harris County. One time we did have a child come from Galveston everyday because his father liked the school so well.

23 SURVEYOR: There is not a group of counties that constitute a catchment area for you then?

24 MRS. McDONALD: No.

25 SURVEYOR: And you are a private organization?

26 MRS. McDONALD: Yes, we operate on tuition fees and some donations from private benefactors.

27 SURVEYOR: And you are the executive director?

28 MRS. McDONALD: Yes.

29 SURVEYOR: What I need from you is a general description of the services you offer and the types of children you serve. You said that you have a special school?

30 MRS. McDONALD: Yes, we operate a day school for deaf children. We instruct them in sign language,

speech, reading, oral language, and all the academic subjects.

31 SURVEYOR: What age child do you serve?

32 MRS. McDONALD: 6-12 years old, first through sixth grades. After they leave here most of them go into public schools. Most of our students can lip read and have some oral language by the time they leave.

33 SURVEYOR: Do you have children who are subcontracted by TEA?

34 MRS. McDONALD: Yes, many of them are, especially the younger ones.

35 SURVEYOR: Do you emphasize any particular instructional methods?

36 MRS. McDONALD: Yes, we use the total communication approach. Our goal is to enable the child to become a normal functioning member of society. We feel the most effective way to do this is to use total communication. That way the child is not held back in the various skill areas while he is learning to speak and lip read.

37 SURVEYOR: I need you to be more specific about the type of child you can serve. I know you serve deaf children, but could you take a deaf/blind child for instance?

38 MRS. McDONALD: No, none of our children have visual impairments. We are really only able to serve children of normal intelligence with hearing impairments. Our children are either totally deaf or have very little hearing.

39 SURVEYOR: You mentioned normal intelligence. You could not serve a child who was deaf and mentally retarded then?

40 MRS. McDONALD: No, the school was originally started for deaf children who were normal and could live at home but needed to attend special schools for their education. We consider ourselves an alternative to residential care. The child can live at home while we meet his educational needs.

41 SURVEYOR: What about a child with a physical handicap?

42 MRS. McDONALD: We have had children with slight handicaps, like a clubbed foot, but nothing major. We couldn't take a child who required special care because of a physical impairment. If it doesn't affect his ability to function, then we would accept him.

43 SURVEYOR: Could you describe your staff for me?

44 MRS. McDONALD: Yes, we have four teachers who are certified in special education and each teacher has an aide. We also have a speech therapist who comes in three times a week. She does speech therapy with the children in addition to what the regular teacher does in the classroom. Then there is myself, the director, and our clerical staff.

45 SURVEYOR: How many children can you serve at full capacity?

46 MRS. McDONALD: Our limit is 50 children.

47 SURVEYOR: How would a child be referred to your service?

48 MRS. McDONALD: Call for an appointment with me. I interview the parents and determine whether we can serve the child appropriately.

49 SURVEYOR: Do you do any testing of the child?

50 MRS. McDONALD: Usually by the time we see a child testing has already been done. I have the parents bring all of the medical and psychological records. If there is any doubt as to the child's ability, we will place him in a classroom for a couple of days on a trial basis. The teacher and I can then tell if the child can be served in our program.

51 SURVEYOR: Do you have a waiting list?

52 MRS. McDONALD: That depends on the time of year and also the age of the child. We might have a waiting list for one age group and not another.

53 SURVEYOR: Do you group the children according to age rather than ability?

54 MRS. McDONALD: Yes, we try to conduct the school as much like public schools as possible. We have enough teachers to individualize for the children as needed so we can keep them in their own age group with their own grade.

55 SURVEYOR: What fees do you charge?

56 MRS. McDONALD: Tuition is $150 a month. Some children get their tuition paid by TEA.

57 SURVEYOR: Do you have any scholarship funds or any other sources of financial aid for parents?

58 MRS. McDONALD: No we don't.

59 SURVEYOR: Can you serve a Spanish-speaking child?

60 MRS. McDONALD: Not if they don't speak any English at all. We don't have anyone on the staff who speaks Spanish.

61 SURVEYOR: Is your school accredited by TEA or any other agency?

62 MRS. McDONALD: Yes, by TEA. We don't have any other particular accreditation.

63 SURVEYOR: Do you provide transportation for your students?

64 MRS. McDONALD: Yes, we subcontract with the school district for bus service.

65 SURVEYOR: Do you offer any other services which are supplementary to your educational program?

66 MRS. McDONALD: No, other than the transportation there isn't anything.

67 SURVEYOR: What hours of the day are you open?

68 MRS. McDONALD: The children are here from 8:30 to 2:30. The office is open until 4:00.

69 SURVEYOR: I think I've gotten all the information I need. I'm going to be sending you a follow-up letter which will further explain what we do and will have our toll-free WATS number in it.

70 MRS. McDONALD: Yes, could I have that number now?

71 SURVEYOR: Certainly, it's 1-800-252-9668.

72 MRS. McDONALD: I know of one family right now that I'm going to refer to you.

73 SURVEYOR: Please feel free to. There is someone here from 8:00 to 5:00 who can take the referrals. I really appreciate your taking the time to talk to me.

74 MRS. McDONALD: No trouble. I enjoyed it very much.

Level I Survey Form: McDonald School

DATE TAKEN________ DATE ENTERED________ SURVEYED BY________

LEVEL I
IDENTIFYING INFORMATION

Name McDonald School for Special Children (14)

Address 108 South Oak (16)

City Houston (16) Zip 68667

Education Service Center Region 4 (16) County of Location Harris (20)

County Catchment Area (includes county of location) (23, 24)

Telephone (713) 478-1256 (17, 18) Auspices (check one): ☐ Public ☒ Private ☐ Proprietary (25,26)

Check One If Appropriate: Direct Affiliation

- ☐ Texas Rehabilitation Commission (TRC)
- ☐ Texas Youth Council (TYC)
- ☐ Mental Health/Mental Retardation (MH/MR)
- ☐ Department of Health Resources (DHthR)
- ☐ State Commission For The Blind (SCB)
- ☐ Department of Human Resources (DHnR)
- ☐ Department of Community Affairs (DCA)
- ☐ Social Security Administration (SSA)
- ☐ Veterans Administration (VA)
- ☐ Texas Education Agency (TEA)

Executive Director Mrs. McDonald (27, 28)

Accreditation TEA (62)

Special Referral Procedures None (47, 48, 49, 50)

SERVICE CLASSIFICATION

	MODE Direct	Subcontracted	Support
ADVOCACY			
☐ Information and Referral			
☐ Legal Assistance			
AID			
☐ Equipment			
☐ Financial			
☐ Housing			
CAMPING			
☐ Day Camping			
☐ Overnight Camping			
COUNSELING			
☐ Psychological			
☐ Parent/Family			
☐ Vocational			
☐ Para-Professional/ Volunteer			
☐ Genetic			
☐ Telephone Hotline			
DAY CARE			
☐ Day Care			
DIAGNOSIS			
☐ Educational			
☐ Psychological			
☐ Psychiatric			
☐ Vocational			
☐ Visual			
☐ Audiological			
☐ Medical			
☐ Total			

	MODE Direct	Subcontracted	Support
EDUCATION			
☐ Regular			
☐ Remedial			
☐ Parent			
☐ Basic Life Adjustment			
(30, 35) ☒ Special	X		
☐ Infant Development			
GENERAL MEDICAL			
☐ General Medical			
RESIDENTIAL			
☐ Detention			
☐ Foster Care			
☐ Care			
☐ Treatment			
☐ Respite			
☐ Halfway House			
SOCIAL/RECREATIONAL			
☐ Social/Recreational			
THERAPY			
☐ Physical			
☐ Occupational			
☐ Psychotherapy			
(44) ☐ Speech			X
☐ Chemotherapy			
TRANSPORTATION			
(63,64) ☐ Transportation			X
VOCATIONAL			
☐ Sheltered Employment			
☐ Vocational Training			
☐ Job Placement			

Level II Survey Form: McDonald School

LEVEL II

Parent Organization McDonald School for Special Children

SERVICE CLASSIFICATION

	MODE*		
	Direct	Subcon-tracted	Support
ADVOCACY			
☐ Information and Referral			
☐ Legal Assistance			
AID			
☐ Equipment			
☐ Financial			
☐ Housing			
CAMPING			
☐ Day Camping			
☐ Overnight Camping			
COUNSELING			
☐ Psychological			
☐ Parent/Family			
☐ Vocational			
☐ Para-Professional/ Volunteer			
☐ Genetic			
☐ Telephone Hotline			
DAY CARE			
☐ Day Care			
DIAGNOSIS			
☐ Educational			
☐ Psychological			
☐ Psychiatric			
☐ Vocational			
☐ Visual			
☐ Audiological			
☐ Medical			
☐ Total			

	MODE*		
	Direct	Subcon-tracted	Support
EDUCATION			
☐ Regular			
☐ Remedial			
☐ Parent			
☐ Basic Life Adjustment			
(30,35) ☒ Special	X		
☐ Infant Development			
GENERAL MEDICAL			
☐ General Medical			
RESIDENTIAL			
☐ Detention			
☐ Foster Care			
☐ Care			
☐ Treatment			
☐ Respite			
☐ Halfway House			
SOCIAL/RECREATIONAL			
☐ Social/Recreational			
THERAPY			
☐ Physical			
☐ Occupational			
☐ Psychotherapy			
(44) ☐ Speech			X
☐ Chemotherapy			
TRANSPORTATION			
(63,64) ☐ Transportation			X
VOCATIONAL			
☐ Sheltered Employment			
☐ Vocational Training			
☐ Job Placement			

*Direct and support modes cannot be checked for the same service.

SPECIAL MODES

Mobile_____

Emergency_____

FEE INFORMATION (55, 56, 57, 58)

Are Services Free to Client?

☐ Yes, always

☐ No

☒ Sometimes

Describe conditions for lowered fees or free service: TEA Contracts

Maximum fee per service unit: $150 per month

Sliding fee scale? ☐ Yes ☒ No

Service wait: (51, 52)

☐ Within 48 hours

☐ Less than one month

☒ More than one month

Duration of Service: (32)

☐ Limited

☒ Unlimited

TYPE OF CLIENT SERVED BY ABOVE SERVICE
RESTRICTED TO:

	Client Type	Age, Sex, and Other Eligibility – (Must be . . .) – *Do not exceed 50 spaces*
☐	Autistic	
☐	Blind and Deaf	
☐	Child with Cerebral Palsy	
☐	Children in Need of Supervision	
☐	Delinquent	
☐	Dependent Neglected	
☐	Drug Abuser*	
☐	Emotionally Disturbed	
☐	Epileptic	
X	Hearing Impaired (30,37,38, 39,40,41, 42)	6-12 years (32)
☐	Health Impaired	
☐	Language/Learning Disabled	
☐	Low Income	
☐	Mentally Retarded, Educable	
☐	Mentally Retarded, Trainable	
☐	Mentally Retarded, Profoundly	
☐	Minimal Brain Injured	
☐	Multiply Handicapped	
☐	Orthopedically Handicapped	
☐	Speech Impaired	
☐	Visually Impaired	

*Drug abuser includes alcoholics; if limited to only drugs or alcohol, specify

LEVEL II
page 3
PROGRAM INFORMATION

Name of Program:

Name and Title of Program Director:

Intake Phone Number:

Address:

Brief Description of Service: Day school 1st-6th grades; instruction in sign, speech, reading, oral languages, all academic subjects (30); use total communication approach (36). Normal IQ (37); no deaf/blind and only very minor physical impairments (40,42).

Average Duration of Program:

Hours and Days of Operation: 8:30 - 4:00, Monday - Friday (68)

Staff: (44)

Numbers	Types	Qualifications
4	Teachers	SED
4	Aides	
1	Speech Therapist (3 times a week)	
1		

Provide direct service for non-English speaking child? Yes ___ No X (59,60)

Types	Language

Legal limitations to certain income levels? No Which?

Legal limitations to certain geographic areas? No Which?

How many can be served at full capacity? 50 (45, 46)

How a referral is made if different from parent organizations:

Respondent: Ms. McDonald

Comments: Grouped by age, school district provides bus service under contract (64)

Discussion of Levels I and II Survey Forms
McDonald School

Level I

Service Classification

This agency offers one basic program which delivers one direct service.

Level II

Service Classification

The program falls within the service classification of special education because the programming is educational and oriented toward a population that cannot progress in a normal classroom setting. There are two services offered in support (transportation and speech therapy).

Type of Child (Level II, page 2)

In this case the resource specialist elicits very clear answers from the respondent concerning what types of clients constitute appropriate referrals to their programs (30, 37, 38, 39, 40, 41, 42)

Comments

This is a straightforward, simple survey, designed to acquaint the resource specialist with the process of fitting a program description into the standardized framework of service classifications and child types.

Transcript II
Survey of St. Joseph Treatment Center

1 RECEPTIONIST: St. Joseph's Treatment Center

2 SURVEYOR: Could I speak to Mrs. McCullough please?

3 RECEPTIONIST: I'll connect you with her.

4 MRS. McCULLOUGH: Community Services

5 SURVEYOR: Mrs. McCullough, this is Carol Jones with the Texas Learning Resource Center in Austin. I believe you received a letter from me last week about what our agency does and the purposes of our surveys.

6 MRS. McCULLOUGH: Yes, I did. I was very interested to hear about your service. Did you receive the written material I sent you about our agency?

7 SURVEYOR: Yes, I did. I've had a chance to look it over and I was wondering if you would have some time now to describe some things further to me.

8 MRS. McCULLOUGH: Yes, I do. Why don't you just ask me whatever you need to know?

9 SURVEYOR: First, I would like to be certain I have the exact legal name of your agency and the address.

10 MRS. McCULLOUGH: We are the St. Joseph's Treatment Center at 412 Copeland Street in San Antonio. Our zip code is 78224.

11 SURVEYOR: I know that you are a private residential treatment center for disturbed children. I need some specific details about the individual programs within your agency. Let's take the residential program first. Could you describe for me the type of treatment you offer to children in residence and the type of child served by this program?

12 MRS. McCULLOUGH: Yes, actually we have three units within our residential treatment program. The children range from 4 to 16 years. We take both boys and girls. Their problems range from neurological dysfunction, hyperactivity to impulsivity. We have children who exhibit extreme acting out behavior, and who are completely out of touch with reality. So, as you can see, we can handle just about the full range of severe emotional disturbance in children. We try to provide a total environment for the child which can meet his needs, using milieu therapy. Each child's treatment plan is developed on the basis of his individual needs by a team of teachers, psychologists, and social workers who are assigned to him. Individual and group psychotherapy are available to the child and his family if needed. His treatment may include remedial teaching, perceptual-motor training, and language therapy. The treatment programs are continually reviewed and updated as the job progresses.

13 SURVEYOR: How long does the average child stay?

14 MRS. McCULLOUGH: Well, we have two basic residential treatment programs. One is for 4-13 year olds who can benefit from up to 2 years of in-patient treatment. These children live in an open cottage setting. The other is our adolescent unit, which houses 12-16 year olds. They usually just stay 4-8 months for psychiatric treatment and stabilization. In both cases, our goal is to get the child back to his family and into regular life as soon as possible.

15 SURVEYOR: You mentioned parents a couple of times. Do you require parent participation while a child is in your residential facility?

16 MRS. McCULLOUGH: Yes, we do. That's a requirement of our program. We have extensive training programs in family therapy for parents while their child is with us. We have training groups for parents in behavior management. We also provide counseling and family therapy, or couples therapy as needed. We try to prepare the family so that it can respond to the child when he's back in the home environment. Parents must be willing to participate in the treatment process of

the child as it is deemed appropriate by the staff in order for us to accept the child for admission.

17 SURVEYOR: Are these services provided only to parents of children in your program?

18 MRS. McCULLOUGH: No. We do insist that parents of our clients take part, but we also offer free training classes for any parent of an ED child who wants to enroll in them. Of course, we can't individualize the training as much as we can for parents of our clients, so we have separate classes for parents of clients and parents of nonclients.

19 SURVEYOR: How would a parent refer a child for your services?

20 MRS. McCULLOUGH: They would call the intake unit which is headed by Dr. Jones. We then do our own screening and diagnostic workup of the child.

21 SURVEYOR: You mentioned that you do your own screening. Are there any particular records the parents must have before a child is referred?

22 MRS. McCULLOUGH: Yes, we need all total, medical, and school records that currently exist on the child. Then we do our own preliminary screening. Usually from this we can tell whether a child will be suitable for our program. In any case, he's placed on the residential unit for a two-week trial period. At the end of that period, we decide whether our program would be suitable for him on a long-term basis.

23 SURVEYOR: I know you have an interdisciplinary staff. Could you give me some specifics about the professions represented on your staff?

24 MRS. McCULLOUGH: Yes, we have Dr. Turner, who is a child psychiatrist and our director. In addition to him we have three clinical psychologists with a Ph.D. We have four master's level psychologists. We have eight special education teachers. Some of them have a BA, some have an MA. We also have eight teacher aides and several child care workers.

25 **SURVEYOR:** Do you have anyone on your staff who speaks Spanish?

26 **MRS. McCULLOUGH:** Yes, we do. One of our psychologists speaks Spanish, and three of our teachers speak Spanish also.

27 **SURVEYOR:** How many children can you handle on the residential treatment units?

28 **MRS. McCULLOUGH:** Our full capacity is 50 in all.

29 **SURVEYOR:** Are there any geographic limitations as far as the children you'll accept for your programs?

30 **MRS. McCULLOUGH:** We take children from Bexar County first. We will take children from surrounding areas, if we have the space for them; however, since parent participation is required in the treatment of the child, most of our clients live in the surrounding area.

31 **SURVEYOR:** What is the maximum fee for your residential treatment service?

32 **MRS. McCULLOUGH:** Our maximum fee is $1,000 a month, but few people ever pay that much. We have a sliding scale which we use, but most of our children are subsidized by United Way or CHAMPUS Insurance.

33 **SURVEYOR:** Is zero the lower limit of your sliding scale?

34 **MRS. MCCULLOUGH:** Yes.

35 **SURVEYOR:** I noticed in your brochure that you have a crisis unit. Is that residential also?

36 **MRS. McCULLOUGH:** Yes, it is. That's our residential acute treatment unit. It's a short-term facility, 1-6 weeks in-patient treatment, for children and adolescents needing emergency psychiatric care. While the child is in the unit we do a total diagnostic workup and try to stabilize him so that he can return to his family after a maximum stay of six weeks and continue outpatient treatment.

37 SURVEYOR: And the staff you have for that facility is identical to the other residential units?

38 MRS. McCULLOUGH: Yes, it is.

39 SURVEYOR: How many children can you handle on the acute treatment unit?

40 MRS. McCULLOUGH: Our full capacity is presently six.

41 SURVEYOR: I take it that you can accept emergency referrals on your acute treatment unit?

42 MRS. McCULLOUGH: Yes, we can. We get many referrals from DPW, doctors, even the school system. We'll take a child almost immediately if the situation is severe.

43 SURVEYOR: What is the turn-around time for the regular residential program?

44 MRS. McCULLOUGH: It depends. Right now we have a waiting list and it would take about 2 or 3 months. This may change however.

45 SURVEYOR: In addition to the residential facilities, your brochure describes a day treatment program. What kind of client does that program serve?

46 MRS. McCULLOUGH: Our day treatment program serves children with a broad spectrum of psychopathology, including character disorders, childhood schizophrenia, and children with a combination of emotional, language, and learning disabilities. The problems of these children may range from school and family maladjustment to extreme aggressiveness toward authority figures, and disruptive behavior in the classroom. The treatment program is designed for children who are behind in academic achievement and cannot be adequately served in public school settings. The program consists of individual and group therapy; a highly structured special education program and speech therapy; consultation from the nursing and psychiatric staff is available to supervise medication and review the medical status of each

child. This program serves children from 8-12 years of age. Our early childhood program serves children 2-8 years and is similar to the program I just described. We have substantially the same staff for these programs as for the residential treatment facility. Children who are in residential treatment also attend these programs during the day.

47 SURVEYOR: It sounds like the main thrust of your day program is educational, with the therapy and consultation as support. Is this accurate?

48 MRS. McCULLOUGH: Yes, it is. As I said, we depend on the day treatment program to provide the educational programming for our residential clients as well as to serve those the public schools can't handle.

49 SURVEYOR: So then it would be appropriate to refer a child to your institution for out-patient psychotherapy alone?

50 MRS. McCULLOUGH: We couldn't provide it unless he was actually in the day treatment program or a residential client.

51 SURVEYOR: Can you provide the same diagnostic work-up for kids coming into the day program as you can for the residential clients?

52 MRS. McCULLOUGH: Yes.

53 SURVEYOR: Where do most of your referrals come from?

54 MRS. McCULLOUGH: Most of the children who attend our day programs are subcontracted by TEA. They attend here instead of going to public schools, because public school does not have an adequate program for them.

55 SURVEYOR: So, most of the children do not pay any fee for attending the day treatment program?

56 MRS. McCULLOUGH: Yes, that's correct. Those that do pay on a sliding scale basis.

57 SURVEYOR: What are the upper and lower limits of the scale?

58 MRS. McCULLOUGH: It varies from zero to $200 per month, but no one pays the maximum amount.

59 SURVEYOR: And do you provide transportation for the children who attend only during the day?

60 MRS. McCULLOUGH: Yes, we do. They're transported by bus, which is subcontracted from the public school system.

61 SURVEYOR: And how many children can you serve in the day program specifically?

62 MRS. McCULLOUGH: We can take 80 children now.

63 SURVEYER: Do you have a waiting list for the day program?

64 MRS. McCULLOUGH: Not at the moment, so we could take a child pretty quickly.

65 SURVEYOR: Is there anything else you can think of that you offer in the way of services that we haven't talked about?

66 MRS. McCULLOUGH: No, I think we've covered everything; the residential programs, day programs, emergency services, and parent training.

67 SURVEYOR: One last thing. Are you accredited or licensed by anyone?

68 MRS. McCULLOUGH: Yes, we are fully accredited by JCAH.

69 SURVEYOR: Well, I believe that just about covers it. If I find any gaps in my information may I call you back?

70 MRS. McCULLOUGH: Certainly.

71 SURVEYOR: Thank you for your time. Good-bye.

Level I Survey Form: St. Joseph's Treatment Center

DATE TAKEN________ DATE ENTERED________ SURVEYED BY________

LEVEL I
IDENTIFYING INFORMATION

Name St. Joseph's Treatment Center

Address 412 Copeland (10)

City San Antonio (10) Zip 78224 (10)

Education Service Center Region 20 County of Location Bexar

County Catchment Area (includes county of location) ________

Telephone 512-997-8246 Auspices (check one): ☐ Public ☒ Private ☐ Proprietary

Check One If Appropriate: Direct Affiliation

☐ Texas Rehabilitation Commission (TRC)
☐ Texas Youth Council (TYC)
☐ Mental Health/Mental Retardation (MH/MR)
☐ Department of Health Resources (DHthR)
☐ State Commission For The Blind (SCB)
☐ Department of Human Resources (DHnR)
☐ Department of Community Affairs (DCA)
☐ Social Security Administration (SSA)
☐ Veterans Administration (VA)
☐ Texas Education Agency (TEA)

Executive Director Dr. Turner (24)

Accreditation JCAH (68)

Special Referral Procedures ________

SERVICE CLASSIFICATION

	MODE			
	Direct	Subcontracted	Support	
ADVOCACY				
☐ Information and Referral				
☐ Legal Assistance				
AID				
☐ Equipment				
☐ Financial				
☐ Housing				
CAMPING				
☐ Day Camping				
☐ Overnight Camping				
COUNSELING				
☐ Psychological			X	(12,16)
☐ Parent/Family			X	(16)
☐ Vocational				
☐ Para-Professional/ Volunteer				
☐ Genetic				
☐ Telephone Hotline				
DAY CARE				
☐ Day Care				
DIAGNOSIS				
☐ Educational			X	(12)
☐ Psychological			X	(12)
☐ Psychiatric			X	(24)
☐ Vocational				
☐ Visual				
☐ Audiological				
☐ Medical				
☐ Total				

		MODE		
		Direct	Subcontracted	Support
	EDUCATION			
	☐ Regular			
	☐ Remedial			
(46)	☒ Parent	X		X
	☐ Basic Life Adjustment			
(12,46,48)	☒ Special	X		X
	☐ Infant Development			
	GENERAL MEDICAL			
	☐ General Medical			X
	RESIDENTIAL			
	☐ Detention			
	☐ Foster Care			
	☐ Care			
(12,14 36)	☒ Treatment	X		
	☐ Respite			
	☐ Halfway House			
	SOCIAL/RECREATIONAL			
	☐ Social/Recreational			
	THERAPY			
	☐ Physical			
	☐ Occupational			
(12,24)	☐ Psychotherapy			X
(46)	☐ Speech			X
(46)	☐ Chemotherapy			X
	TRANSPORTATION			
(59,60)	☐ Transportation			X
	VOCATIONAL			
	☐ Sheltered Employment			
	☐ Vocational Training			
	☐ Job Placement			

Level II Survey Form: St. Joseph's Treatment Center

LEVEL II (A)

Parent Organization St. Joseph's Treatment Center

SERVICE CLASSIFICATION

	MODE*			
	Direct	Subcontracted	Support	
ADVOCACY				
☐ Information and Referral				
☐ Legal Assistance				
AID				
☐ Equipment				
☐ Financial				
☐ Housing				
CAMPING				
☐ Day Camping				
☐ Overnight Camping				
COUNSELING				
☐ Psychological			X	(12,16)
☐ Parent/Family			X	(16)
☐ Vocational				
☐ Para-Professional/ Volunteer				
☐ Genetic				
☐ Telephone Hotline				
DAY CARE				
☐ Day Care				
DIAGNOSIS				
☐ Educational			X	(12)
☐ Psychological			X	(12)
☐ Psychiatric			X	(24)
☐ Vocational				
☐ Visual				
☐ Audiological				
☐ Medical				
☐ Total				

		MODE*		
		Direct	Subcontracted	Support
	EDUCATION			
	☐ Regular			
	☐ Remedial			
(18)	☐ Parent			X
	☐ Basic Life Adjustment			
(48)	☐ Special			X
	☐ Infant Development			
	GENERAL MEDICAL			
(46)	☐ General Medical			X
	RESIDENTIAL			
	☐ Detention			
	☐ Foster Care			
	☐ Care			
(12,14)	☒ Treatment	X		
	☐ Respite			
	☐ Halfway House			
	SOCIAL/RECREATIONAL			
	☐ Social/Recreational			
	THERAPY			
	☐ Physical			
	☐ Occupational			
(12)	☐ Psychotherapy			X
(46)	☐ Speech			X
(46)	☐ Chemotherapy			X
	TRANSPORTATION			
	☐ Transportation			
	VOCATIONAL			
	☐ Sheltered Employment			
	☐ Vocational Training			
	☐ Job Placement			

*Direct and support modes cannot be checked for the same service.

SPECIAL MODES

Mobile ______

Emergency ______

FEE INFORMATION (32,34)

Are Services Free to Client?

☐ Yes, always

☐ No

☐ Sometimes

Describe conditions for lowered fees or free service: United Way; CHAMPUS; Sliding Scale to Zero

Maximum fee per service unit: $1000 per Month

Sliding fee scale? ☒ Yes ☐ No

Service wait:

☐ Within 48 hours

☐ Less than one month

☒ More than one month (44)

Duration of Service:

☒ Limited (14)

☐ Unlimited

LEVEL II (A)
page 2

TYPE OF CLIENT SERVED BY ABOVE SERVICE
RESTRICTED TO:

	Client Type	Age, Sex, and Other Eligibility – (Must be . . .) – *Do not exceed 50 spaces*
☐	**Autistic**	
☐	**Blind and Deaf**	
☐	**Child with Cerebral Palsy**	
☐	**Children in Need of Supervision**	
☐	**Delinquent**	
☐	**Dependent Neglected**	
☐	**Drug Abuser***	
(12) ☒	**Emotionally Disturbed**	(14) 4-16 years (16,18) w parent participation
☐	**Epileptic**	
☐	**Hearing Impaired**	
☐	**Health Impaired**	
☐	**Language/Learning Disabled**	
☐	**Mentally Retarded, Educable**	
☐	**Mentally Retarded, Trainable**	
☐	**Mentally Retarded, Profoundly**	
☐	**Minimal Brain Injured**	
☐	**Multiply Handicapped**	
☐	**Orthopedically Handicapped**	
☐	**Speech Impaired**	
☐	**Visually Impaired**	

*Drug abuser includes alcoholics; specify under "Other Eligibility"

119

PROGRAM INFORMATION

Name of Program: Residential

Name and Title of Program Director:

Intake Phone Number: Same, ask for Dr. Jones

Address:

Brief Description of Service: Milieu therapy (12); individual/group psychotherapy (12); attend day program for special ed. (48); (See Level II on Day Treatment Program; parent participation mandatory (16, 18); intake includes a 2 week trial period (22); 2 units: 1) ages 4-13, and 2) 12-16 (14).

Average Duration of Program: Ages 4-13 -- 2 years Ages 12-16 -- 4-8 months (14)

Hours and Days of Operation:

Staff: (24)

Numbers	Types	Qualifications
1	Director/child psychiatrist	
3	clinical psychologists	Ph.D.
4	psychologists	M.A.
8	special ed. teachers	B.A. and M.A.
8	teachers aides	
	child care workers	

Provide direct service for non-English speaking child? Yes X No ___

Types	Language
1 psychologist and 3 teachers	Spanish (26)

Legal limitations to certain income levels? No Which?

Legal limitations to certain geographic areas? No Which? preference to Bexar (30)

How many can be served at full capacity? 50 (28)

How a referral is made if different from parent organizations:

Respondent: Ms. McCullough

Comments: Wants all records on child for use in screening for intake. (22) Waiting period varies - presently 2 - 3 months (44)

LEVEL II (B)

Parent Organization St. Joseph's Treatment Center

SERVICE CLASSIFICATION

	MODE* Direct	MODE* Subcontracted	MODE* Support	
ADVOCACY				
☐ Information and Referral				
☐ Legal Assistance				
AID				
☐ Equipment				
☐ Financial				
☐ Housing				
CAMPING				
☐ Day Camping				
☐ Overnight Camping				
COUNSELING				
☐ Psychological			X	(36)
☐ Parent/Family				
☐ Vocational				
☐ Para-Professional/ Volunteer				
☐ Genetic				
☐ Telephone Hotline				
DAY CARE				
☐ Day Care				
DIAGNOSIS				
☐ Educational			X	(36,38)
☐ Psychological			X	(36,38)
☐ Psychiatric			X	(36,38)
☐ Vocational				
☐ Visual				
☐ Audiological				
☐ Medical				
☐ Total				

		MODE* Direct	MODE* Subcontracted	MODE* Support
	EDUCATION			
	☐ Regular			
	☐ Remedial			
	☐ Parent			
	☐ Basic Life Adjustment			
	☐ Special			
	☐ Infant Development			
	GENERAL MEDICAL			
	☐ General Medical			
	RESIDENTIAL			
	☐ Detention			
	☐ Foster Care			
	☐ Care			
(36)	☒ Treatment	X		
	☐ Respite			
	☐ Halfway House			
	SOCIAL/RECREATIONAL			
	☐ Social/Recreational			
	THERAPY			
	☐ Physical			
	☐ Occupational			
(36,38)	☐ Psychotherapy			X
	☐ Speech			
(36, 38)	☐ Chemotherapy			X
	TRANSPORTATION			
	☐ Transportation			
	VOCATIONAL			
	☐ Sheltered Employment			
	☐ Vocational Training			
	☐ Job Placement			

*Direct and support modes cannot be checked for the same service.

SPECIAL MODES

Mobile______

Emergency X (41,42)

FEE INFORMATION

Are Services Free to Client?

☐ Yes, always

☐ No

☐ Sometimes

Describe conditions for lowered fees or free service: ?

Maximum fee per service unit: ? per______

Sliding fee scale? ☐ Yes ☐ No

Service wait: (41,42)

☒ Within 48 hours

☐ Less than one month

☐ More than one month

Duration of Service:

☒ Limited (36)

☐ Unlimited

130

TYPE OF CLIENT SERVED BY ABOVE SERVICE
RESTRICTED TO:

		Client Type	**Age, Sex, and Other Eligibility** – **(Must be . . .)** – *Do not exceed 50 spaces*
	☐	**Autistic**	
	☐	**Blind and Deaf**	
	☐	**Child with Cerebral Palsy**	
	☐	**Children in Need of Supervision**	
	☐	**Delinquent**	
	☐	**Dependent Neglected**	
	☐	**Drug Abuser***	
(36)	X	**Emotionally Disturbed**	4-16 years
	☐	**Epileptic**	
	☐	**Hearing Impaired**	
	☐	**Health Impaired**	
	☐	**Language/Learning Disabled**	
	☐	**Mentally Retarded, Educable**	
	☐	**Mentally Retarded, Trainable**	
	☐	**Mentally Retarded, Profoundly**	
	☐	**Minimal Brain Injured**	
	☐	**Multiply Handicapped**	
	☐	**Orthopedically Handicapped**	
	☐	**Speech Impaired**	
	☐	**Visually Impaired**	

*Drug abuser includes alcoholics; specify under "Other Eligibility"

LEVEL II (B)
page 3
PROGRAM INFORMATION

Name of Program: Crisis Residential

Name and Title of Program Director:

Intake Phone Number:

Address:

Brief Description of Service: CRISIS intervention for 1-6 weeks; diagnostic and stabilization; out patient counseling after exit (36)

Average Duration of Program: Up to six weeks (36)

Hours and Days of Operation:

Staff:

Numbers	Types	Qualifications
Same as previous Level II on residential treatment		

Provide direct service for non-English speaking child? Yes X No

Types	Language
	Spanish

Legal limitations to certain income levels? No **Which?**

Legal limitations to certain geographic areas? No **Which?** Preference to Bexar (30)

How many can be served at full capacity? 6 (40)

How a referral is made if different from parent organizations:

Respondent: Ms. McCullough

Comments:

LEVEL II (C)

Parent Organization St. Joseph's Treatment Center

SERVICE CLASSIFICATION

	Direct	MODE* Subcontracted	Support	
ADVOCACY				
☐ Information and Referral				
☐ Legal Assistance				
AID				
☐ Equipment				
☐ Financial				
☐ Housing				
CAMPING				
☐ Day Camping				
☐ Overnight Camping				
COUNSELING				
☐ Psychological				
☐ Parent/Family			X	(46)
☐ Vocational				
☐ Para-Professional/Volunteer				
☐ Genetic				
☐ Telephone Hotline				
DAY CARE				
☐ Day Care				
DIAGNOSIS				
☐ Educational			X	(51,52)
☐ Psychological			X	(51,52)
☐ Psychiatric			X	(51,52)
☐ Vocational				
☐ Visual				
☐ Audiological				
☐ Medical				
☐ Total				

		Direct	MODE* Subcontracted	Support
	EDUCATION			
	☐ Regular			
	☐ Remedial			
(18)	☐ Parent			X
	☐ Basic Life Adjustment			
(46)	☐ Special	X		
	☐ Infant Development			
	GENERAL MEDICAL			
	☐ General Medical			
	RESIDENTIAL			
	☐ Detention			
	☐ Foster Care			
	☐ Care			
	☐ Treatment			
	☐ Respite			
	☐ Halfway House			
	SOCIAL/RECREATIONAL			
	☐ Social/Recreational			
	THERAPY			
	☐ Physical			
	☐ Occupational			
(46)	☐ Psychotherapy			X
(46)	☐ Speech			X
(46)	☐ Chemotherapy			X
	TRANSPORTATION			
(59,60)	☐ Transportation			X
	VOCATIONAL			
	☐ Sheltered Employment			
	☐ Vocational Training			
	☐ Job Placement			

*Direct and support modes cannot be checked for the same service.

SPECIAL MODES

Mobile______

Emergency______

FEE INFORMATION (54,55,56,57,58)

Are Services Free to Client?

☐ Yes, always

☐ No

☒ Sometimes

Describe conditions for lowered fees or free service: TEA; Sliding Scale to Zero

Maximum fee per service unit: $200 per month

Sliding fee scale? ☒ Yes ☐ No

Service wait: (63, 64)

☐ Within 48 hours

☒ Less than one month

☐ More than one month

Duration of Service:

☐ Limited

☒ Unlimited (46)

TYPE OF CLIENT SERVED BY ABOVE SERVICE
RESTRICTED TO:

		Client Type	Age, Sex, and Other Eligibility – (Must be . . .) – *Do not exceed 50 spaces*
	☐	Autistic	
	☐	Blind and Deaf	
	☐	Child with Cerebral Palsy	
	☐	Children in Need of Supervision	
	☐	Delinquent	
	☐	Dependent Neglected	
	☐	Drug Abuser*	
(46)	☒	Emotionally Disturbed	2 - 12 years
	☐	Epileptic	
	☐	Hearing Impaired	
	☐	Health Impaired	
	☐	Language/Learning Disabled	
	☐	Mentally Retarded, Educable	
	☐	Mentally Retarded, Trainable	
	☐	Mentally Retarded, Profoundly	
	☐	Minimal Brain Injured	
	☐	Multiply Handicapped	
	☐	Orthopedically Handicapped	
	☐	Speech Impaired	
	☐	Visually Impaired	

*Drug abuser includes alcoholics; specify under "Other Eligibility"

LEVEL II (C)
page 3
PROGRAM INFORMATION

Name of Program: Day Treatment

Name and Title of Program Director: Same

Intake Phone Number: Same

Address: Same

Brief Description of Service: 2 groups; 1) ages 2-8, 2) ages 8-12 special ed. plus support psych. services for residential and kids from the community who can't go to public school (46, 48). Most of the kids from public schools are there under TEA contracts (54).

Average Duration of Program: ?

Hours and Days of Operation: 8:30 - 2:30 Monday-Friday (printed material)

Staff:

Numbers	Types	Qualifications
Same as residential		

Provide direct service for non-English speaking child? Yes X No ___

Types	Language
	Spanish

Legal limitations to certain income levels? No Which? ___

Legal limitations to certain geographic areas? No Which? Preference to Bexar County

How many can be served at full capacity? 80 (62)

How a referral is made if different from parent organizations: ___

Respondent: Ms. McCullough

Comments: Transportation provided by TEA under contract (60)

LEVEL II (D)

Parent Organization St. Joseph's Treatment Center

SERVICE CLASSIFICATION

	MODE*		
	Direct	Subcontracted	Support
ADVOCACY			
☐ Information and Referral			
☐ Legal Assistance			
AID			
☐ Equipment			
☐ Financial			
☐ Housing			
CAMPING			
☐ Day Camping			
☐ Overnight Camping			
COUNSELING			
☐ Psychological			
☐ Parent/Family			
☐ Vocational			
☐ Para-Professional/ Volunteer			
☐ Genetic			
☐ Telephone Hotline			
DAY CARE			
☐ Day Care			
DIAGNOSIS			
☐ Educational			
☐ Psychological			
☐ Psychiatric			
☐ Vocational			
☐ Visual			
☐ Audiological			
☐ Medical			
☐ Total			

	MODE*		
	Direct	Subcontracted	Support
EDUCATION			
☐ Regular			
☐ Remedial			
(18)☒ Parent	X		
☐ Basic Life Adjustment			
☐ Special			
☐ Infant Development			
GENERAL MEDICAL			
☐ General Medical			
RESIDENTIAL			
☐ Detention			
☐ Foster Care			
☐ Care			
☐ Treatment			
☐ Respite			
☐ Halfway House			
SOCIAL/RECREATIONAL			
☐ Social/Recreational			
THERAPY			
☐ Physical			
☐ Occupational			
☐ Psychotherapy			
☐ Speech			
☐ Chemotherapy			
TRANSPORTATION			
☐ Transportation			
VOCATIONAL			
☐ Sheltered Employment			
☐ Vocational Training			
☐ Job Placement			

*Direct and support modes cannot be checked for the same service.

SPECIAL MODES

Mobile ______

Emergency ______

FEE INFORMATION (18)

Are Services Free to Client?

☒ Yes, always

☐ No

☐ Sometimes

Describe conditions for lowered fees or free service: ______

Maximum fee per service unit: ______ per ______

Sliding fee scale? ☐ Yes ☒ No

Service wait:

☐ Within 48 hours

☒ Less than one month

☐ More than one month

Duration of Service:

☐ Limited

☒ Unlimited

LEVEL II (D)
page 2

TYPE OF CLIENT SERVED BY ABOVE SERVICE
RESTRICTED TO:

		Client Type	Age, Sex, and Other Eligibility – (Must be . . .) -- *Do not exceed 50 spaces*
	☐	Autistic	
	☐	Blind and Deaf	
	☐	Child with Cerebral Palsy	
	☐	Children in Need of Supervision	
	☐	Delinquent	
	☐	Dependent Neglected	
	☐	Drug Abuser*	
(18)	X	Emotionally Disturbed	
	☐	Epileptic	
	☐	Hearing Impaired	
	☐	Health Impaired	
	☐	Language/Learning Disabled	
	☐	Mentally Retarded, Educable	
	☐	Mentally Retarded, Trainable	
	☐	Mentally Retarded, Profoundly	
	☐	Minimal Brain Injured	
	☐	Multiply Handicapped	
	☐	Orthopedically Handicapped	
	☐	Speech Impaired	
	☐	Visually Impaired	

*Drug abuser includes alcoholics; specify under "Other Eligibility"

PROGRAM INFORMATION

Name of Program: Parent Ed

Name and Title of Program Director:

Intake Phone Number:

Address:

Brief Description of Service: (18) Free parent training classes for parents of any ED child; not necessary that child be in residential or day treatment program. Program includes family therapy, behavior management and counseling.

Average Duration of Program:

Hours and Days of Operation:

Staff:

Numbers	Types	Qualifications
Same		

Provide direct service for non-English speaking child? Yes X No

Types	Language
	Spanish

Legal limitations to certain income levels? No Which?

Legal limitations to certain geographic areas? No Which? preference to Bexar

How many can be served at full capacity?

How a referral is made if different from parent organizations:

Respondent: Ms. McCullough

Comments:

Discussion of Levels I and II Survey Forms

St. Joseph's Treatment Center

Level I

Identifying Information

All of the identifying information was obtained from the "written material" mentioned on page 1 of the transcript (6). Some of it was double-checked (9, 10) early in the interview.

Service Classification

This grid is a summary of the agency's services and an index to the Level II surveys which follow. Services offered both directly and as support to other direct services are checked in both boxes on the Level I grid.

Level II

There are three direct services indicated on the Level I service classification grid. These are parent education, special education, and residential treatment. The program information supplied by the respondent indicates three residential programs which can be represented on two Level II survey forms (II-A and II-B). The day treatment program and early childhood programs are both classified as special education and can also be represented within a single Level II form (II-C). The parent education program delivers one direct service and is covered in Level II-D.

Level II-A

1. Service Classification - This Level II pertains to the direct service of residential treatment. The respondent provides an overview of the programs involved in responses 12 and 14. Although the respondent begins by saying there are "3 units" within the residential program (12), the discussion focuses on the two programs described in response 14. There are several differences in these two programs, but they are both classified as residential treatment and do not differ in aspects which necessitate

considering them as separate direct services or using more than one Level II form to enter them (i.e., they have the same support services, fees, serve the same child type, etc.). Thus, the situation is one in which, from a referral management point of view, there are two programs delivering one direct service (See "Introduction to Resource Information Bank"). The third "unit" referred to in response 12 is also classified as a residential treatment service but is not described until responses 36 through 42. This program is the "crisis unit" and is covered in Level II-B.

2. Duration of Service (Level II-A, page 1) - The two programs delivering this direct service each have different limitations in service duration, but the key fact is that they are both limited. Thus, no conflict is created by this item. The different limitations are described on page 3 of this Level II.
3. Type of Client Served (Level II-A, page 2) - The description of the primary client type served by these programs falls within the definition of emotionally disturbed as it is defined within Appendix K. Although the two programs serve two different age ranges (response 14), the direct service is available to the total range of ages. Response 16 makes it clear that parent participation is an important requirement of their program; thus, the descriptor "w/parent participation" is entered in the spaces following the age range.
4. Program Information (Level II-A, page 3) - The information on this page is specific to each of the two programs included within the single direct service covered in this Level II. The resource specialist has the option of completing a separate page 3 of the form for each program, but in this case the programs were similar enough that all the data could be put on a single form.

Level II-B

1. Service Classification - This Level II form pertains to the crisis unit referred to in response 36. Although the direct service is classified as residential treatment, this service cannot be covered in the same Level II as the other residential programs because certain storage items differ (e.g., support services, special modes, other eligibility).

2. Fees - The topic of fees for the crisis unit was not discussed in the interview; thus, these items cannot be completed. The resource specialist may have simply assumed that the fees for all residential programs at St. Joseph's are the same, but there is no evidence to support this assumption. It is quite common to discover areas which were not covered adequately in a survey interview, especially with large, multiservice agencies. In this case a second telephone call is warranted to explore this and other aspects of the survey.
3. Program Information (Level II-B, page 3) - The staff for the crisis unit is identical to the staff for the other residential programs; thus, there is no need to repeat this information.

Level II-C

1. Service Classification - This Level II form pertains to the two programs described in response 46. The respondent calls one of them a "day treatment" program and the other an "early childhood" program. From the description given by the respondent, the surveyor correctly classifies both programs as delivering the single direct service of special education (47, 48), with the primary distinguishing feature between the programs being the age ranges served. Since all other storage information (e.g., support services, fees, eligibility) are identical, only one Level II form is needed.

Level II-D

1. Service Classification - This Level II pertains to the training classes for parents described in response 18. This is another service which is offered directly and also as support for other direct services.
2. Type of Child Served (Level II-D, page 2) - The child type checked here refers to the children, even though the parents are the direct recipients of the service.

Summary

This survey is an excellent example for illustrating some of the ways in which an agency's programs are translated into terms of direct and support services within

111

the information bank. It should be apparent that the resource specialist must be highly familiar with the structure of the forms, definitions of services, and child types in order to make the proper decisions to complete the survey. It is not necessary, however, that agency respondents be familiar with the system in order for the survey to be completed. As long as the respondent has a thorough knowledge of the agency's programs, staff, and policies, the trained resource specialist can put this information into the language of the information bank. As previously mentioned, it is often necessary to speak with more than one person in an organization in order to obtain adequate information. It is also often necessary to make a second contact with the agency to fill in gaps in the survey which go unnoticed in the initial interview but surface when the forms are coded.

The major areas of this survey are complete as they stand. However, there are a few areas in which the surveyor did not obtain precise information. Unanswered questions are enumerated below:

1. Is the day treatment program operational year-round or only during the nine-month academic year?
2. What is the average duration of the day treatment program?
3. Do children in the crisis unit participate in the day treatment program? If not, more details of their daily programming should be entered on page 3 of Level II-C.
4. The respondent states that the age range served by the day treatment program is 2-12 years. Given this limitation, what sort of educational programming is provided for children 13-16 years in the residential treatment program?
5. What are the fees for the crisis unit?
6. Is parent participation mandatory in the crisis and day treatment programs?
7. What is the average duration of the parent education program and what are the hours and days of meeting times? Is there a service wait for this program?

Chapter 6

TRAINING ACTIVITIES FOR THE REFERRAL SPECIALIST

TRAINING ACTIVITIES FOR THE REFERRAL SPECIALIST

Chapter 1 and the introduction to Chapter 5 describe the rationale behind the Texas Education Agency's decision to establish a regional direction service center in each of the 20 education service centers. Each operation was adapted to meet the unique needs of that particular region. Staff members of the State Direction Service Center trained referral and resource specialists to prepare them for their particular functions. Chapter 5 dealt entirely with the resource specialist training. Chapter 6 will deal with the training activities of the referral specialist workshops.

The referral training involved several different types of activities. These included information-sharing with representatives from major service providers, dissemination of packets describing other significant resources throughout the state, problem-solving sessions focusing on difficult referrals currently being handled by the regional centers, and small-group discussions of sample cases illustrating key issues which the referral specialist must face routinely. This chapter is devoted entirely to those issues, which involve confidentiality, advocacy, comprehensive needs assessment, and case management.

Brief case histories and transcripts of actual conversations between referral specialists and referring agents are used to introduce the issues. The transcripts in this chapter and in Appendix O have also been included so that the reader may modify them and perhaps develop other training activities to suit their own needs. In most cases these transcripts were used to illustrate common mistakes a referral specialist may make when interviewing a client and are not exemplary of ideal interview techniques. The presentation of each case history or transcript is followed by a group discussion in which the trainer serves as facilitator. The discussion guide accompanying each issue is not intended to provide an ideal solution to the issue. It is intended to facilitate a stimulating discussion between the trainer and trainees regarding potential problems, in the hope that each direction service center will be better able to handle similar situations.

The training exercises are not sequential; each can be presented independently. However, the introductory transcripts for some exercises are identical, and if a trainer desires to use those exercises with trainees, a more cohesive discussion will follow if the exercises are presented together.

Case Management

This exercise focuses on a number of important issues involved in case management activities. A case history is presented in which a parent of a handicapped child is seeking noneducational services. A discussion follows which deals with establishing priorities for locating services, relevance of noneducational services, strategies for more efficient use of the referral specialist's time, and ways in which a direction service center can assist the public schools.

Case History

An unemployed mother of two children ages three and four contacted the State Direction Service Center. The mother and her two children had been living with relatives; however, due to the added financial strain on the relatives they had been asked to move. The mother expressed a desire to work, but needed a day-care program for the children while she looked for employment. The three-year-old child seemed to be normal, but the four-year-old child was nonverbal and nonambulatory. Limited information was provided by the mother as to the cause of the child's retarded development. The mother stated that no public services were being provided and that day care centers were very hesitant to work with handicapped children. The mother contacted the Center to request assistance in locating food, clothing, shelter, day-care services, and a job so she could support her family.

Issues for Discussion

Issue

The parent prioritized the needs of herself and her family as follows:

1. Food (immediate need)
2. Shelter (immediate need)
3. Clothing (immediate need)
4. Day-care services for children
5. Employment

What additional needs can you identify, and how would you integrate them with the needs already identified and prioritized by the mother?

Discussion

The parent has identified a set of needs which are basic to the survival of her children (food, shelter and clothing). Satisfying the parent's need for employment would help to resolve these needs more permanently. Although the parent is aware that the four-year-old child is not developing normally, she sees the educational needs of the handicapped child as secondary to the survival needs of the family.

Additional needs that might be identified by the referral specialist after investigating the situation are:

Medical evaluation
Educational evaluation
Educational program
Speech and physical therapy
Special equipment for child
Medication
Continued medical intervention
Transportation

After the referral specialist has identified additional needs, it then becomes necessary to integrate those needs with the needs identified by the parent and to rank order all the needs. The following list rank orders those needs. Obviously, another parent and referral specialist may prioritize the needs differently.

A discussion follows the list of needs to clarify the rationale for prioritization.

1. Food
2. Shelter
3. Clothing
4. Medical evaluation
    Medicine
    Continued medical intervention
5. Educational evaluation
6. Education program
    Speech therapy
    Physical therapy
    Special equipment
    Transportation
7. Day care
8. Transportation to day care and home
9. Employment

There is no doubt that the immediate needs of food, shelter, and clothing identified by the parent are the most urgent. Because of the severe developmental delay of the four-year-old child, it is doubtful that a day-care service could be identified that would enroll the child without a complete medical evaluation. After this evaluation was performed, it would be the responsibility of the public schools to provide an educational evaluation and to develop a program tailored to meet the educational needs of the child. Transportation from the child's home to school and back, speech therapy, physical therapy, and any special equipment needed to meet the child's needs would be included as part of the educational program. After the referral specialist involved the school in developing an educational program, efforts would center on identifying a day-care facility, assuming the necessary financial resources could be located. Additionally, transportation from school to the day-care facility and to the home would be required. It is possible the school would transport the child to the day-care center; however, another resource would probably be needed to transport the child home from the day-care center. Not until this point could the parent turn her full attention to seeking employment. Although the mother had listed day care as fourth with regard to urgency (see issue), in reality the priority of this need was superceded by three additional needs related to the handicapped child (see 4, 5, and 6 above).

151

The parent had prioritized employment as fifth with regard to urgency, but this need was subsequently prioritized ninth. The need for further medication and medical intervention would have been determined in the initial medical evaluation (item 4 above).

Issue

Many of the identified needs of this family are not directly related to the educational needs of the handicapped child. Where do you believe the responsibilities of a referral specialist begin and end with regard to noneducational needs?

Discussion

Local direction service policies will dictate the amount of involvement the referral specialist will have in directing parents to services which are not directly related to educating the handicapped child. For example, if a center's primary responsibility is to direct a parent to educational services, the center may not wish to become involved in directing a client to services to satisfy food, shelter, and clothing needs. However, before a parent is willing to consider educational needs, the more urgent survival needs must be satisfied. Each center will need to determine how much effort should be spent directing parents to services not related to the primary focus of the center. However, the referral agent should take care not to cause the parents to think that again they are being thwarted in their attempts to locate services for their handicapped child.

In this particular case the referring agent was initially requesting food, shelter, clothing, day-care services, and assistance with finding employment. None of these services was directly related to the education of a handicapped child; however, because of the obvious need for a variety of services for the nonambulatory and nonverbal child, the referral specialist assisted the parent in obtaining the most urgent needs first. In this case the parent could not be concerned with locating educational services for her handicapped child when she did not know where the family would be living or whether they would have food to eat. By refusing to assist with these basic needs, the referral specialist may cause the parent to become so frustrated as to refuse all assistance from the Center.

Issue

What strategies could be developed to relieve the referral specialist of much of the work involved in locating services to meet the noneducational needs of the family? What resources could be utilized to assist in obtaining the noneducational services?

Discussion

Interagency coordination is extremely important to a successful direction service operation. In many instances a handicapped child will need a variety of services which can only be provided by multiple resources. Knowing what resources to explore for these services, the criteria for eligibility, and contact people within each agency to determine the availability of these services requires successful interagency coordination. Just as a direction service center relies on other agencies for referrals, the direction service center should in turn refer its clients to appropriate resources when the services being requested are not the primary focus of the center's activities. While a center should recognize the necessity of meeting such fundamental needs as food, shelter, and clothing, other agencies exist whose primary goal is to locate services to meet those needs.

Another strategy is to determine what the capabilities of the referring agent are and to become involved only to the point of ascertaining that the client has reached appropriate resources. If the referring agent is capable of pursuing these services independently, then the name, address, and telephone number of the resource might suffice. If, on the other hand, the referring agent has become very frustrated in trying to locate services, the referral specialist might feel obligated to make the initial appointment and even to assist with locating transportation. Thus, the referral specialist encourages the referring agent to assume as much responsibility for case management as possible.

Housing and Urban Development, a federally funded program, has housing projects and assists low-income clients by paying an amount equal to a certain percent of their income for rent. The only requirements are that the client must reside within the housing project and be in need of financial assistance. Other county resources, such as a housing assistance payment program, will pay a percentage of the client's rent. Again, the client must be able to justify a need and be willing to assume responsibility for finding a house to rent. Other city-operated resources subsidize portions of the client's rent and even utilities if a need can be demonstrated. The Welfare Department is a major resource when a need is demonstrated for food assistance. Additionally, religious organizations maintain food pantries and will often provide a two- to three-day emergency food supply. Community organizations such as Goodwill Industries and junior leagues provide assistance with clothing needs.

Issue

Why should the referral specialist encourage parents to take an active role in obtaining services for a handicapped child? How can the referral specialist assist parents in doing so?

Discussion

Whenever possible, the referral specialist should enlist the aid of the parents in contacting resources and determining their appropriateness and availability. By taking an active role in this process, parents often reduce their feelings of helplessness and frustration in locating services for their child. The more confidence parents have in their ability to provide for their handicapped child's needs, the more likely it is that a positive, nurturing atmosphere will exist in the home and family.

In some cases the referral specialist can assist by coaching parents in tactics for approaching agencies. For example, if the parents have a good idea of what records and documents will be needed, they can send these in advance of their meeting with agency officials. It is also wise for them to write down as much as possible of what transpires each time they contact an agency. This written record should include the names of persons spoken to, the date and time of the contact, and the content of the conversation. Probably the most common problem parents have in dealing with service providers is that they do not ask enough questions. One way of encouraging parents to be more assertive is to have the parents be present while the referral specialist takes the lead in discussing the case with an agency's staff member. In this way the referral specialist serves as a model for the parent's subsequent contacts with other agencies. If necessary, the referral specialist can also give the parents a list of specific questions to ask and can suggest further lines of questioning depending upon the agency's initial answers. Helping parents to develop their communication skills can enhance the parents' sense of competency in caring for their child and can be a valuable by-product of the family's experience with direction service.

Issue

How can a direction service center assist the public schools in meeting the requirements of Public Law 94-142?

Discussion

Public Law 94-142 emphasizes the importance of locating services for the unserved and severely handicapped child, and of developing appropriate individual educational plans (IEP). A direction service center can assist the public schools in many ways. In some instances, parents are not aware that services are available for younger children and consequently overlook many possible resources, including public schools. For this reason, a direction service center can be instrumental in identifying previously unserved children who are severely handicapped. Providing services for these children at an early age is imperative if the child is to reach his or her optimal level of functioning. Referral to public schools when appropriate would facilitate the delivery of early educational intervention.

A direction service center can also assist parents in locating services for very young children who are not eligible for the services of public schools. Local physicians, clinics, and hospitals are usually the first to identify these children. A direction service center can direct parents to appropriate resources and inform school personnel when a child becomes eligible for public school services. Additionally the center can assist the schools by providing them with client records. A center that is working with a particular family will have accumulated considerable information and knowledge regarding the needs of a client. Maintaining this information and making it accessible to the local school district when the child becomes eligible for services can reduce the need for unnecessary diagnostic work and speed up the time it takes to secure all necessary client records.

The center can assist the public schools by identifying potential resources to provide related services. Making schools aware of the total spectrum of services within the community makes it more likely that the school will specify in the IEP the full range of related services needed by the child. For example, if the IEP calls for physical therapy, the referral specialist could assist in locating resources, which might include transportation and financial assistance for those services not provided by the school. Frequently a handicapped child is identified who needs assistance, and the school counselor does not have time to assume case management responsibility. If the referral specialist can assume some of the responsibility, a significant portion of the extra workload imposed by Public Law 94-142 can be shifted from already overburdened school personnel. Often the referral specialist is already involved and could very easily provide the necessary legwork.

Setting Limits for Confidentiality

The following conversation is an excerpt from an initial interview with an associate psychologist from a local school district. This interview is used to discuss the limits within which a referral specialist can preserve the confidentiality of certain types of information.

Prior to the point we enter the interview, the conversation has centered on the school's problem in obtaining a neurological evaluation for the child. A discussion of the child's medication history has also revealed that the parents have provided only limited cooperation with the school.

Interview

RS=Referral Specialist RA=Referring Agent

RS: 1 Why were the parents not given the drug to administer over the summer?

RA: 2 Well, this is a case where the parents have possibly abused the child. Dr. Outler at the clinic said it probably would be best if they didn't administer the medication because they might give him two or three tablets when he only needs one, or they might skip a long time and then give him three or four. He wasn't sure we could trust the parents' judgment, so we just had our school nurse give it to him here.

RS: 3 Did you have the parents' permission to do that?

RA: 4 Yes. I typed it up, went and talked to the mother. She agreed and signed it. She's perfectly willing for us to give him the medication.

RS: 5 You have not been back to Dr. Outler?

RA: 6 No. Because I would have to go through the Director of Special Education and the way the money is, he probably wouldn't release it, and the parents won't take him back to the clinic. That's our next step, but the parents won't take him. We are in need of a more complete workup before we embark on another medication program.

RS: 7 If they won't take him, will they give someone else permission to do so?

RA: 8 Yes. They would give us permission to take him, but our budget is already overextended.

RS: 9 Sounds like you're having to work around a pretty tough situation there with the parents.

RA: 10 Right.

RS: 11 Can you tell me to what extent you have involved the welfare department in this case?

RA: 12 None. I don't believe they're on welfare.

RS: 13 Well, you say that the child is possibly abused. What evidence is there and to what extent is that true to your knowledge?

RA: 14 It's the school's opinion that he seems to be psychologically abused. It's as if the parents are telling him to do something and then showing him by their actions that they don't mean it. It's a doublebind situation. For example, they may be telling him "yes, I love you"; then they show him by their actions that they don't love him. They're inconsistent at home.

RS: 15 Oh, I see. That's a bit different. That clears it up for me.

RA: 16 Can I tell you things in confidence?

RS: 17 All of this information is confidential. I will keep the information here in a file that I won't give out to anybody unless I have the parent's permission.

RA: 18 Okay. All right. Let me tell you one more thing then. This child has been physically abused. He came to school one day and could barely get around. We dug into it and his Daddy had whipped him; beat him up the night before with an extension cord. He did this simply because our principal had called the parents and asked them to come to school just to talk about Larry. Now, I know that particular incident was not called in because we were afraid if we called in they would do it again. So it wasn't reported and that's why it's real touchy.

Issue for Discussion

Issue

In your opinion, how should the referral specialist handle the information he or she had just received? What courses of action are open to the referral specialist and what are the possible consequences of these actions?

Discussion

It is stressed in other exercises that a referral specialist must always protect the client's and family's right to confidentiality. This exercise introduces a different aspect of the confidentiality issue. Here the referring agent is a professional within a public school. The referring agent asks for and receives blanket assurance of the confidentiality of the information and then divulges knowledge of an incident of child abuse. Texas law mandates that any person with knowledge of child abuse or neglect must report that knowledge to the proper authorities; failure to do so constitutes a misdemeanor. It is clear in this case that the primary responsibility for notifying the authorities rests with the school personnel. Their failure to do so places the referral specialist in a difficult position.

The school's fear of the parents' further abuse of the child as a result of an investigation appears to be justified. It cannot be assumed that reporting the incident will automatically result in the child's being removed from the home. However, unless intervention occurs it is unlikely that the home situation will improve or that educational programming for the child will be successful. There is no precedent in Texas which provides definitive legal guidance for a person with second-hand knowledge of child abuse. The most desirable option, from the referral specialist's point of view, is for the school to reconsider its position and to report the abuse to local authorities. If school officials cannot be convinced to do this, then the referral specialist must weigh several factors in making his or her decision whether to report the case.

These factors include the specificity of the referral specialist's knowledge (e.g., Does the referral specialist know the child's name or address?), the policy of the direction service center, and the referral specialist's own ethical judgment of the particular situation.

Each direction service center must become familiar with existing laws governing the referral specialist's liability in such cases. Within these legal requirements each center should set policy which will guide the referral specialist in dealing with sensitive information. It is advisable for the referral specialist to have a prepared sentence or two which can be stated whenever someone asks about the center's stance on confidentiality. For example, a more appropriate response to the referring agent's question in response 16 might have been: "All our information is confidential within the limits set by law. Our written records are subject to court subpoena and there are certain situations in which we are obligated to report information to the proper authorities." This statement gives clear warning that although the center's intent is to keep all information confidential, there are situations in which this is impossible.

The laws governing individual responsibility for reporting information pertaining to criminal acts such as child abuse are constantly being rewritten through legislation and are reinterpreted through litigation. Each direction service center should keep abreast of current developments in its state's courts and legislature to protect both referring agent and referral specialists and provide the most effective management of difficult cases such as this.

Advocacy

The topic of this exercise is the role of the referral specialist regarding his or her stance as an advocate for clients. A segment of the dialogue is included here from the transcript in Appendix O. This excerpt between the referral specialist and friend of the handicapped child's family provides the basis for a discussion which leads the participants to examine several possible consequences of the referral specialist's responses.

Transcript Excerpt
Responses 39-44

RS=Referral Specialist		F=Friend
RS:	39	How many children were in Crystal's room?
F:	40	Well, there were about 30, and they all had problems of one kind or another. I mean, Crystal didn't get to letters and she was there six months. They colored, and Crystal, of course, can't color. So she never got any service. Now that is what I feel like is the problem. Crystal can do the work. She could do the reading. I told Crystal's mother she ought to get her a cheap little typewriter.
RS:	41	That is a fine idea.
F:	42	I tried to get her to do it for all of last year, but she said no, she is too slow and she didn't think they would let her take it to school. I thought, well I mean, she can't write legibly and she can't color. I feel like she can do the work, but she is too slow.
RS:	43	In reading the literature and the advertisements, did you understand that we have these kinds of projects because handicapped children have the same right as other children to receive a free, public education?

F: 44 I didn't read that off the sign, but I have always felt that way. I told Cheryl that it is just not fair that they do her that way. She can't really afford to put her in a private school. She has two other children.

Issues for Discussion

Issue

In responses 39 and 40 the referral specialist and friend discuss Crystal in terms of her previous classroom placement. The friend in response 40 suggests the use of a typewriter, and in response 41 the referral specialist makes a favorable reply. How would you have interpreted response 41 if you were the friend, and what are its potential implications.

Discussion

In a situation where the referring agent is a friend of the child's family, the referral specialist must use extra discretion in his or her responses. The fact that the mother did not call the direction service center herself suggests the possibility that she is somewhat passive and/or has been very frustrated in her attempts to get services for her child. When responding to this type of referring agent, the referral specialist should be aware that the friend might be calling primarily to "check out" the direction service center for the parent. If this is the case, a lack of responsiveness to the friend could create a similar lack of responsiveness in the parent. In response 40 the friend mentions a remediation technique (typewriter) she had suggested to the parent. The referral specialist's unqualified support for this idea in response 41 leads the friend to reveal that the mother had resisted this suggestion. This indicates that there might be some conflict between the parent and the friend about how to help the child. Although response 41 supports the friend, it opens the door to two possible negative consequences. If conflict does exist between the parent and friend, the friend might interpret the response by the referral specialist as an indication of general support for her position. If she then presents it to the parent as such, the referral specialist/parent relationship may be damaged before direct contact is even made. The second negative consequence could occur if the parent or friend present the referral specialist's statement to local school officials as evidence that appropriate educational services had not been offered.

Information obtained from sources other than the individual(s) with primary responsibility for the child should be considered unconfirmed until verified by appropriate sources. It is clear that there is insufficient data to support any specific remediation techniques at this point in the referral process.

A more ideal response could have supported the friend but would have stopped short of endorsing a particular technique. For example, the referral specialist could have said, "It sounds like you care a great deal about the family and have been a lot of help to them." This promotes rapport between the referral specialist and the friend but does not force the referral specialist into a premature stance regarding the case.

Issue

What factors determine the degree to which a referral specialist assumes the role of advocate for a child and his or her family? What are your own and your center's policies regarding the referral specialist's role in this particular area?

Discussion

In response 43 the referral specialist informs the friend of every handicapped child's legal right to educational services. It is important to recognize that in doing so, the referral specialist functions as an advocate for the child. Advocacy roles can vary from simply seeking services for children to entering into legal efforts to obtain services. By virtue of the direction service center's unique position, the referral specialist is usually limited in how strong an advocate's role s/he may assume. These limits are imposed by the necessity for a direction service center to maintain a neutral position in the event of conflict between families and service providers. These limits will vary from one center to another depending upon local policies. Each referral specialist must familiarize himself or herself with the center's policies and assume an advocacy stance within these limits. For example, a parent may contact a direction service center and request information about speech therapy services. A referral specialist could discuss with the parent the speech therapy services that are available through the local education agency (LEA). If it appeared the child was eligible for services and none were being provided, the referral specialist could inform the parent of the child's right to receive related services such as speech therapy from the public school and could even discuss possible reasons why the schools were not providing these services. On the other hand, a referral specialist who cannot assume such a strong advocacy role might only provide information on private or public services but not directly discuss the LEA's responsibility.

It is also important to take into account the degree to which a parent or other referring agent perceives the referral specialist as an advocate. Even if strong advocacy statements are not made by the referral specialist, the type of assistance provided by a direction service center is often perceived as an advocacy function. When a referral specialist works directly with a referring agent to identify appropriate resources, assists in obtaining the services, and provides conscientious followup, it is difficult for the referring agent not to expect the referral specialist to be a strong advocate if conflict should arise in the case. Consequently, it is important for the referral specialist to communicate clearly to the referring agent the limits of the advocacy function. If strong advocacy action is needed, such as in a lawsuit or formal hearing, the referral specialist can put the family in touch with a parent group or other advocacy organization.

Capabilities of a Direction Center

This exercise focuses on the issue of communicating the capabilities and limitations of a direction service center. In many cases a referring agent has little knowledge of the functions of a direction service center. A brief, concise explanation is imperative if a referring agent is to fully understand how a direction service center can be of benefit. Additionally, overselling the benefits of a center will only serve to create false expectations on the part of the referring agent. The following excerpt is a segment of the same transcript presented in Appendix O.

Transcript Excerpt
Responses 50-51

RS=Referral Specialist F=Friend

F: 50 What will you do to help?

RS: 51 Well, first of all, we gather all the information about the child's past history and record it as accurately as possible. If a parent or someone else is complaining about the quality of service a child is receiving, we encourage them to appeal to the school and ask the school personnel to reconsider their child's educational program and perhaps to put the child in a different one. We always let the people know what their rights are as parents of handicapped children and maybe try to get them even involved with some of the local parent groups. We will follow this referral through until Crystal gets the services she needs. You see, the Texas Education Agency has what is called Plan A for special education, which funds school districts to encourage them to put the handicapped child back into the classroom as much as possible. Now Crystal's problems don't make her abnormal. She should be with other children her age as much as possible.

Issues for Discussion

Issue

What major functions of direction service are described by the referral specialist in response 51? What are some of the negative aspects of the referral specialist's reply?

Discussion

Referring agents who contact direction services often do so without a clear understanding of the capabilities and limitations of the direction service. They may call a direction service as a result of acquiring a toll-free number from posters, radio, or television advertisements. A referral specialist must be prepared to explain these capabilities and limitations in the initial contact with the referring agent. Although the referral specialist's first sentence in response 51 was accurate, the rest of the reply does not answer the question asked by the referring agent. The referral specialist only deals with contingencies specific to this case and does not take the opportunity to integrate this with a general overview of the capabilities of direction service. For example, the referral specialist discusses the issue of a conflict between parent and school. While this is a relevant issue for the client, discussing it at this point with a referring agent who is a friend of the client is premature. The rest of the referral specialist's conversation is a fragmented description of a complicated educational process whereby the state education agency funds local school districts to provide special education services to handicapped children. This information is likely to create more confusion for the referring agent than it resolves.

Issue

What additional functions of direction service should have been described to the referring agent?

Discussion

In addition to the information-gathering activities mentioned by the referral specialist, the response should have mentioned the functions listed below, along with an explanation of each function.

Determining the child's unmet needs.

Identifying appropriate services through the information bank of resources.

Confirming the availability of services.

Assisting families to obtain the services either by providing information to them directly or by contacting the resources to make initial appointments and obtaining confidentiality records on behalf of the client.

Providing follow-up to assess the referring agent's satisfaction with the services being delivered and to offer additional assistance necessary.

Drawing Conclusions Based on Unconfirmed Data

Based on a conversation with a referring agent, a referral specialist makes statements which at the time they were made could not be substantiated with existing data. In this case the statements imply that the referral specialist has made a professional judgment which is in agreement with the referring agent, who is not the parent of the child in question. A discussion follows which indicates the possible outcome of such statements and alternate responses are provided. This excerpt is a segment of the transcript presented in Appendix O.

Transcript Excerpt
Responses 50-51

F: 50 What will you do to help?

RS: 51 Well, first of all, we gather all the information about the child's past history and record it as accurately as possible. If a parent or someone else is complaining about the quality of service a child is receiving, we encourage them to appeal to the school and ask the school personnel to reconsider their child's educational program and perhaps to put the child in a different one. We always let the people know what their rights are as parents of handicapped children and maybe try to get them even involved with some of the local parent groups. We will follow this referral through until Crystal gets the services she needs. You see, the Texas Education Agency has what is called Plan A for special education, which funds school districts to encourage them to put the handicapped child back into the classroom as much as possible. Now Crystal's problems don't make her abnormal. She should be with other children her age as much as possible.

Issues for Discussion

Issue

What position (or role) does it appear the referral specialist has taken in relationship to this child and referring agent?

Discussion

Initial referral information generally consists of a combination of facts and individual perceptions. The latter includes perceptions by both the referring agent and the referral specialist which may or may not be accurate. Drawing conclusions based on unconfirmed data could put the referral specialist in the position of having to retract statements, which ultimately could cause the referring agent to lose confidence in the referral specialist's professional abilities. In the last two sentences of response 51, the referral specialist takes a position which supports the friend--he or she agrees that the child is normal. However, the referral specialist does not have adequate data to justify this response; further, he or she should assume that all conversations shared with the friend will be relayed to the parent. The entire transcript has shown that a potential conflict between the parents and the school exists. Thus, the referral specialist's statements could aggravate, rather than alleviate, this potential conflict. Referral specialists should be very cautious about sharing a hypothesis about the case prematurely.

Issue

What do you perceive as the possible benefits and ill effects of such a statement?

Discussion

The referral specialist has conveyed to the friend the impression that the information provided has been accepted as factual; thus, a bond of agreement has taken place. This obviously will benefit the referral specialist, who can expect cooperation from the friend who feels supported. Unfortunately, if the referral specialist's opinion is not confirmed by data, the friend may be unwilling to accept more appropriate suggestions from the referral specialist since the friend may continue to adhere to the more desirable initial judgment made by the referral specialist.

Issue

Specify a different statement which could have been made.

Discussion

An alternative statement might have been: "It is your impression that Crystal is normal, or more normal than abnormal. If your impression is correct, it would be more appropriate for Crystal to be with other children her own age as much as possible." The referral specialist might then discuss how data are confirmed through interviews with parents, schools, and other agencies.

Creating Unrealistic Expectations for the Referring Agent

This exercise illustrates how a referral specialist in an initial interview can create unrealistic expectations on the part of the referring agent. In this conversation the referral specialist inadvertently leads the referring agent to believe the direction service center can provide a service that in reality can not be guaranteed. A discussion follows which outlines the potential positive and negative aspects of such statements and provides alternative responses for the referring agent. This excerpt is a segment of the transcript presented in Appendix O.

Transcript Excerpt
Responses 50-51

F: 50 What will you do to help?

RS: 51 Well, first of all, we gather all the information about the child's past history and record it as accurately as possible. If a parent or someone else is complaining about the quality of service a child is receiving, we encourage them to appeal to the school and ask the school personnel to reconsider their child's educational program and perhaps to put the child in a different one. We always let the people know what their rights are as parents of handicapped children and maybe try to get them even involved with some of the local parent groups. We will follow this referral through until Crystal gets the services she needs. You see, the Texas Education Agency has what is called Plan A for special education, which funds school districts to encourage them to put the handicapped child back into the classroom as much as possible. Now Crystal's problems don't make her abnormal. She should be with other children her age as much as possible.

Issues for Discussion

Issue

In response 51 the referral specialist makes the statement "We will follow this through until Crystal gets the services she needs." In your opinion, what inference would the referring agent make from this remark?

Discussion

A referral specialist must attempt to gain the confidence of the referring agent both in the capabilities of that individual as a referral specialist and in the services direction service has to offer. The statement "We will follow through until Crystal gets the services she needs" has two implications:

> The referral specialist will work with the referring agent until services are obtained.
>
> The direction service center is capable of insuring service delivery.

To some extent, the first implication is appropriate. A referral specialist should continue to provide assistance until the referring agent is aware of all possible service options. One alternative may be to acquire temporary services, i.e., part-time special class attendance until a permanent alternative such as a residential program can be obtained. The referral specialist fails to acknowledge that appropriate services may not be obtained due to situations out of the center's control, i.e., service not in existence, service unavailable at the time, or a resistance of the service provider to render the service. Instead, this statement implies that the referral specialist has an unlimited ability to obtain service for this child.

Issue

What are some positive and negative payoffs of such a statement?

Discussion

A statement of this nature would obviously be perceived as very positive by the referring agent and would certainly promote her confidence that a source of help had finally been located. However, the referring agent's expectations of the services direction service can provide may be elevated to unrealistic proportions based upon that same statement. Neither a referral specialist nor direction service center can guarantee that the client will receive appropriate services as implied in this statement. When a referral specialist makes a statement of this kind, he or she risks losing the respect of the referring agent/client when he or she is unable to fulfill these expectations later. The referral specialist can gain the confidence of the referring agent/client much more realistically by providing accurate information about what direction service can and cannot be expected to provide.

Issue

What do you feel prompted the response?

Discussion

When a referral specialist talks with a referring agent who has obviously become frustrated with trying to obtain services for a handicapped individual, the natural tendency is to make the referring agent feel that the direction service will end that frustration. Other responses can be used to make the referring agent feel comfortable and confident about the services direction service can provide without creating false expectations. Both direction service and the referral specialist have limitations which must be recognized and accepted by the referral specialist and communicated to the referring agent.

Issue

Specify a different response that might have achieved more positive results.

Discussion

A more appropriate response would state that the referral specialist will assist the referring agent until services are obtained or until it becomes evident that services cannot be obtained. For example, "I want to assure you we will assist in locating appropriate services for Crystal. We obviously cannot guarantee that those services are available or even that they exist, but we will continue our pursuit until we locate the services or it becomes evident that those services cannot be obtained at this time. In either case, we will maintain contact with you to provide additional information and assistance as needed."

Setting Priorities

This exercise concerns a nonambulatory, six-year-old cerebral palsied child in need of day care, financial assistance, and transportation. The discussion leads participants to consider identified needs, potential services, relative priorities, barriers to service, and activities with which the referral specialist could assist the referring agent.

Case History

A six-year-old girl with cerebral palsy was referred to direction service. The mother reported the child was nonambulatory and limited to scooting along the floor. Hearing and vision were described as normal. Educational services were provided by the public school and the mother had always been home to care for the child after school. Recently the mother had enrolled in a college program and was to begin classes in the summer.

In a month, the public school program would close for the summer and the parent requested assistance in locating a day-care program while she attended classes. Since the parent expected to be in classes at the end of the school day in the fall, she also needed information concerning after-school programs. Additionally, the local school district made the parents aware of a six-week physical therapy program offered during the summer at the local university. Financial resources and transportation were needed to enable the child to receive physical therapy services for six weeks in the summer. The mother was concerned about the constant care which the child demanded, and she expressed a desire to explore short-term (1-2 years) residential programs. Again, financial resources were needed since Supplemental Security Income (SSI) payments had been discontinued a month prior to the actual referral date.

Issues for Discussion

Issue

What are the identified needs and potential services to meet each need?

Discussion

Based on the brief introduction, the following needs can be identified and matched with potential services to meet those needs.

Evident Needs	Potential Services
A place to care for the child after school while the mother attends college classes in the fall.	After-school program (program specifically designed to serve children after school hours, i.e., 2 p.m. to 6 p.m.)
Someone to care for child in summer while mother attends college classes	Day-care program (program designed to care for children, generally to accommodate children of working parents).
Twenty-four hour care	Short-term residential program. Financial resources for the service.
Physical therapy	Transportation to university physical therapy program. Financial resources for PT program.

Issue

Does one need have priority over another?

Discussion

The referral specialist and referring agent determine the needs and together prioritize those needs. Needs which are basic to life, such as food, shelter, and medical care, are obviously dealt with first. Needs which are of most concern to the referring agent are generally dealt with next, while educational needs, if different from the concerns of the referring agent, are considered last. After priorities have been established it is the responsibility of the referral specialist to determine the most appropriate method for obtaining the needed services. Generally the availability of information about resources and the ease with which the services can be obtained determine the referral specialist activities at this point. If the referring agent is a parent, he or she would normally not be involved in this decision-making process because decisions are based on knowledge of the service delivery system rather than on the child and family. If the referring agent is a case worker from another agency, he or she may also aid the referring agent in determining the most appropriate course of action.

The case presented is an example of a situation in which multiple needs exist. Jointly identifying the client's needs enables both parties to set priorities before the referral specialist begins to locate services that are critical to meeting the immediate needs of the child and family. After the immediate needs are met, less critical needs can be explored. Involving the parents in prioritizing the needs of the handicapped child provides parents with the opportunity to be directly involved in the decisions being made about their child.

In this particular situation, the following needs have been prioritized; one and two are considered immediate needs, while three and four are considered less critical.

1. Day care program while the mother attends summer college classes.

2. Physical therapy.

3. After school care while mother attends fall college classes.

4. Twenty-four hour care (residential program).

The needs which demand immediate attention are someone to care for the child during the day while the mother attends summer classes and physical therapy. Resources which the referral specialist must identify are those which provide day-care services, transportation services, and financial aid for physical therapy services. Again, the needs are prioritized according to the urgency of the situation. In this case, the child's school program is to end in one month; therefore, a day-care program must be located immediately. Services related to physical therapy are given second priority because the university physical therapy program does not begin for two months. Setting the day-care program as the first priority does not necessarily mean the referral specialist will actually identify resources to meet this need first; neither does it imply that after resources are identified the child will be able to obtain the services of any day-care program. Rather, it recognizes the fact that attempts need to be made to obtain this service first.

After identifying the day-care service, or concluding that no service to meet this need exists, the referral specialist would attempt to identify transportation and financial resources for the physical therapy services. Since the provision of physical therapy is contingent upon locating two resources, the referral specialist would probably have to simultaneously identify services to meet both needs.

During the summer, the referral specialist would have an opportunity to locate after-school and residential programs (needs 3 & 4). There is some confusion in requesting resources which provide these services, for in one instance the parent is requesting resources to complement the local school program and in another, she requests residential placement away from home. This suggests one of two things: the parent wants the referral specialist to identify resources for both services to ensure an alternative choice or the parent is undecided about which service is preferred. In situations where the referring agent is indecisive, the referral specialist will have difficulty setting priorities. A need may exist to intervene and discuss the implications of each alternative in order for the parent to make a final decision about which resource is preferred. It is also possible that the referring agent and referral specialist will determine both needs have equal priority. Assuming it is necessary to identify both resources, the referral specialist might prioritize activities from the standpoint of which resource can be identified more quickly or which service can be obtained more quickly once it is identified. In this particular case three reasons exist for initially identifying after-school programs. First, the information to identify after-school programs is more readily available because only local resources have to be explored. On the other hand, residential services and financial resources to obtain the services would require a statewide search involving more exploration time to pursue. The second reason is that the after-school program would probably be more accessible at least from the standpoint of available financial resources. Since residential placements are very expensive and the parent has asked for assistance in locating financial resources, it is clear that this may not be the easiest service to obtain. The possibility of obtaining after-school care could be hindered by factors such as waiting lists; however, the probability of identifying a resource and enrolling a child in an after-school program would still be greater than that of a residential program. A third reason for exploring the after-school program initially is that this placement would allow the child to remain in the home. However, after all factors have been considered, it might be decided that the after-school program is not the best placement because the child might not receive the most appropriate educational services in this arrangement. Additionally, environmental variables related to the home might make residential placement more attractive. If it is still necessary for the referral specialist to identify residential services and financial resources, the referral specialist would then pursue this task. Resources for all three services--after school, residential, and financial--might be presented to the parent at the same time for a decision.

Issue

What obstacles or barriers exist which might impede the attainment of appropriate services?

Discussion

Obstacles and barriers invariably arise which may impede the attainment of appropriate services for the handicapped child. One evident obstacle is financial resources for both physical therapy and residential services. Another potential problem is the indecisiveness of the parent. Until she can establish her own priorities in terms of the fall program, it is doubtful that she will be committed to obtaining either service.

Resources to meet other needs may exist, but there are potential obstacles to obtaining these services. Day-care and after-school programs exist in most communities; however, the child's handicap may be an obstacle because day-care and after-school programs for the handicapped are limited in some communities. Another potential obstacle might be locating day-care or after-school programs in close proximity to the other services the child is receiving. In the summer, day-care programs would need to be close to the child's home and accessible to anyone providing transportation to the physical therapy program. In the fall, if after-school care was necessary, it must be located close to the public school to prevent transportation from becoming an obstacle. Another potential problem might be finding someone to transport the child to the after-school program, i.e., school personnel, parent, private/public transportation service. Potential services should be carefully analyzed with regard to their merits, liabilities, and obstacles to overcome in obtaining the service.

Issue

With what activities could the referral specialist assist the referring agent?

Discussion

In this particular situation the referring agent could assist with the following:

1. Obtaining additional information about past and present educational programs from the local school.

2. Obtaining information regarding the recommended instructional arrangement for the forthcoming school year from the local school.

3. Obtaining information regarding the child's current level of functioning from the local school.

4. Obtaining medical records on the child which might help in obtaining appropriate services. These records would probably be obtained from physicians, clinics, and perhaps hospitals.

5. As potential resources were identified, the referring agent could contact each and provide the referral specialist with his or her opinion.

Data Gathering and Needs Assessment

This exercise is based on the following transcript, in which an interview is conducted by a referral specialist with the father of a seven-year-old visually impaired son who has spent two years in a residential center. The residential center director has informed the parents they must find another placement for the child within two months. It is implied during the interview that the child has behavioral problems that preclude his living at home. Issues for discussion focus on the information gained by the referral specialist, its value, additional informational needs, and sources for obtaining it.

Transcript B

RA=Referring Agent RS=Referral Specialist

RA: 1 Hello, my name is Mark Ryan. I live in Dawson and I need help in finding a school for my son. Dr. Davis at the Meadow's Center in Jasper said that you might be able to help.

RS: 2 Well, Mr. Ryan, I'll do what I can. This a direction service center and we help people locate services for handicapped children, but we do not offer any direct services to children at this center. After determining what you need for your child, we will attempt to locate agencies or individuals that can provide that service. You mentioned that a Dr. Davis from the Meadows Center referred you to the direction service center. Tell me a little about that.

RA: 3 Dr. Davis is over the Meadows Center in Jasper. It's a place for children with learning and physical problems.

RS: 4 Is this a residential home, where children live, or is it a day program?

RA: 5 My son stays there all of the time. My wife and I live here in Dawson.

RS: 6 Mr. Ryan, tell me about your son and how you think I can help you.

RA: 7 Well, my son Donald is seven years old and he is in the Meadows Center. The problem is he's going to have to leave there in two months and I need a new school for him.

RS: 8 What kind of problem does Donald have that makes it necessary for him to be in the Meadows Center?

RA: 9 He can't see.

RS: 10 Are you saying that Donald is totally blind?

RA: 11 No, he's not completely blind. He can see a little. I think the people said he's legally blind.

RS: 12 All right. Now, if I understand you correctly, Donald is seven years old, legally blind, and is in a residential program that he must leave in two months. Why does he have to leave the Meadows Center?

RA: 13 Dr. Davis called and said she couldn't work with him anymore. It seems that they can't work with blind children anymore.

RS: 14 How long has Donald been in the Meadows Center?

RA: 15 He's been there for two years.

RS: 16 Has this been at your expense?

RA: 17 Yes, it has. My wife and I worked overseas for a year so that we could afford this school. We know a new school will be expensive, but we can afford it if fees aren't much more than the $700 a month we're paying now.

RS: 18 Please tell me some more about Donald. Does he have any problems other than the visual ones?

RA: 19 Not that I know about. He was born with visual problems. My wife and I kept him at home with us until he was five. Then we decided to put him in this school.

RS: 20 Prior to the time Donald went to the Meadows Center did anyone evaluate or work with him?

RA: 21 When he was born, we lived near Houston. He was evaluated by doctors at the Children's Medical Center. We spent the next five years making visits to that place every six months to discuss his progress or any problems. A caseworker was assigned from the Blind Commission in Jasper. His name was Mr. Dobson. He helped us with home programs and relayed information to the Medical Center. After Donald went to Meadows, we discontinued the trips to Houston. Since Donald has been at Meadows they have taken care of everything. We pay the bills for any tests he needs which they can't provide.

RS: 22 How often are outside evaluations done?

RA: 23 About once a year. Dr. Davis takes Donald to Houston for testing of some kind.

RS: 24 I'm sure Dr. Davis would have all the information provided following these evaluations. Does Donald have all of his self-help skills such as toileting, dressing, and feeding himself?

RA: 25 I personally think he can do all of those things. But, when he's home, which is only once or twice a year, we have to do so much for him. I really feel that he uses us when he's home, but I think he does whatever those poeple at the center ask him to do.

RS: 26 So, you feel there is a difference between his actual abilities and what he does when he's home with you and your wife.

RA: 27 I sure do. He causes so much trouble for us. In addition to waiting on him constantly, we have to watch every move he makes. He's so destructive, always bothering things. We have to put anything of value out of his reach because he'll destroy everything!

RS: 28 Have you talked with Dr. Davis about the differences which you mentioned? Both she and her staff would probably like to know how you feel about this. If your feelings are correct, the staff would probably like to work toward obtaining consistency in Donald's performance at school and at home.

RA: 29 No. We haven't mentioned it. Generally, we don't see her when we go to the school for Donald.

RS: 30 We need to talk a little bit more about your son and his program at the Meadows Center. I would like to know if there are any medical or specific learning problems that I need to be aware of and the instructional services that are provided to him. This will help me as I look at services available in different residential schools.

RA: 31 He's always been very healthy. I guess he's had the same illnesses as other children, but nothing of major consequence. As for learning problems, I expect that his blindness causes learning problems. No one has ever suggested that he isn't normal in every other way. I know he attends some kind of classes at Meadows, but I don't know exactly what they do with him.

RS: 32 Mr. Ryan, so far we have talked about Donald's problems, his present program and the need to change programs. One thing I'm curious about is whether the public school has been explored as a resource for your son? He's been eligible for public school services for some time now.

RA: 33 This school has nothing to offer him. They have difficulty working with normal children. I doubt if they could do anything with Donald. Before I put him in Meadows, I checked with Jack Richards, who's over the special programs. It seemed as if my child was too different for any of them. Besides, I feel the residential school is the best thing for all of us. Do you think a public school could work with a child like Donald?

RS: 34 First of all, I don't know enough about Donald or your local school district services to state whether they can serve him appropriately. That can be determined after information is obtained from Dr. Davis and after talking with the director of special education in Dawson. I just felt it might be worth your while to explore the possibility of any additional services which might have been developed in the school over the past couple of years since Donald has been in the residential school. One thing which you should be aware of is that all school districts are required to provide a free and appropriate educa- to children. This includes providing residential services, if the school district's staff determines it is the most appropriate arrangement.

RA: 35 Well, perhaps, but right now I'm only concerned with the residential places and I have no desire to get involved with trying to get the school district to provide anything.

RS: 36 I would like to contact Dr. Davis to obtain additional information about the program which she is presently providing to Donald. Do you have any objections to that?

RA: 37 I have no objections, but I thought you could just tell me about some of the programs now.

RS: 38 There are several residential schools throughout the state that work with visually impaired children. It would be helpful to talk with her to determine what the staff at Meadows has been providing to Donald, so that I could attempt to locate a program with comparable services to meet all of his needs. If I only gave you a list of schools for visually impaired children without getting information from Dr. Davis, I don't think it would be as effective.

RA: 39 I feel certain that she will tell you anything you need to know.

RS: 40 Since all records about children are confidential, I'm sure that Dr. Davis will request authorization from you before any information is released to the direction center. I would like to send two authorization forms to you. One will authorize Dr. Davis to release verbal or written information to me about Donald. The other will authorize me to talk to other schools about working with Donald. I'll send self-addressed stamped envelopes so that you can forward the authorization to Dr. Davis and return the other form to my office. In the meantime, I'll call Dr. Davis so she will know that I will attempt to help you. Do you have any questions?

RA: 41 My only concern is how much time this whole thing is going to take. We only have two months and with all of these forms, it seems like we're in for a lengthy procedure.

RS: 42 I understand your concern, and I assure you that we'll do everything possible to assist you as quickly as possible. The forms are necessary for everyone's protection as well as to get information to determine the best possible services for your son. Locating and obtaining residential services sometimes takes a long time. If it is absolutely necessary for Donald to leave Meadows within two months, it may be necessary for him to return home for a short time. Because of this I would like your permission to contact the director of special education in Dawson to determine what services are available in the school district.

RA: 43 It's okay with me if you call them, but I doubt if they can help. When will you send me the forms you talked about?

RS: 44 I'll put them in the mail today. I'll need your address as well as Dr. Davis'. Since I understand the basic need, I'll begin looking through our information bank to get a list of residential schools that serve visually impaired children. I'll look at specific program content after receiving information from Meadows Center. I'll call the school district after talking to Dr. Davis. Then I'll recontact you to talk about schools which might be able to work with Donald. In the meantime, please feel free to call me if I can assist you in any way.

RA: 45 I do hope this doesn't take too long. We are very anxious to find a new school before the two months are up.

RS: 46 I'll make every effort to gather the information as quickly as possible.

Issue for Discussion

Issue

The referral specialist will need information other than that gained from this interview in order to proceed with the case. What additional information would you seek, and what sources would you contact for this information?

Discussion

Additional pieces of information needed are listed below and are paired with the likely source(s) for that information.

Information Needed	Source of Information
Additional information about child's abilities	Present service provider (Meadow's Center)
Potential resources for the child	State Direction Service Center information bank and present service provider
Present appropriateness/ availability of resources	Professional contacts in residential schools
Local capabilities	Local education agency representatives

The father stated that the child is legally blind. However, in order to assist him, the referral specialist must have details about specific visual, motor, and learning abilities and must know any special instructional arrangements necessary for working with the child, e.g., a special class for visually impaired children or a regular class with special help. This includes information about special books, visual aids, or other equipment. He or she must also determine the child's ability to care for himself, e.g., feeding, dressing, and toileting skills.

A maximum amount of information allows the referral specialist to take an individualized approach to finding residential schools that can meet the specific needs of this child. He or she is also in a better position to provide information to the family so it can choose the resource which is most appropriate.

The logical source of information about the child's current program, capabilities, and weaknesses is the current service provider, which is the residential school. Its staff members can discuss the appropriateness of continuing the child's treatment and can identify additional unmet needs of the child. Any recent assessments can be discussed and, if necessary, sent to the referral specialist. After the information about the child's abilities is gathered, the referral specialist can identify possible resources. Some resources may have been suggested by the current service provider, who usually can suggest other programs with which it has had experience. Other resources can be identified through the State Direction Service Center's information bank. Other sources of information are:

1. Agencies which provide similar services but cannot meet the child's needs because of factors such as service cost, age limitations, or geographic restrictions.

2. Special interest groups, such as the Association for Retarded Citizens or the Association for Children with Learning Disabilities.

3. Individuals with a professional interest in that particular type of child, such as university professors who train students to work with children with specific handicaps.

4. Resource directories from other agencies.

5. Local public school. Even though the father expressed negative feelings about the local school, it is important to contact the director of special education to determine whether services are available because there may be an interval between the time the child leaves the current residential center and enters a new residential program. Even if the local school is incapable of providing the needed services,

it should be made aware of the case so it can determine its responsibilities.

This search usually reveals several possible resources. The referral specialist then determines whether these resources are appropriate and available. They are appropriate if they offer a comparable or more extensive program than the current service provider.

In summary, the referral specialist determines two things about the possible resources;

1. Whether they are appropriate to meet the child's needs.
2. Whether they are available.

Confidentiality of Client Records

The referral transcript presented in the previous exercise entitled "Data Gathering and Needs Assessment" makes it clear that additional information gathering is necessary before the referral specialist can proceed with the case. A list of the informational needs and sources of the information follows. Collecting this information requires contacts with each of the sources listed.

Information Needed	Source of Information
Additional information about child's abilities	Present service provider (Meadow's Center)
Names of potentially appropriate resources for child	Direction service center information bank and present service provider
Availability and appropriateness of potential resources	Professional contacts in residential schools
Capabilities of public schools	Local education agency representatives

The discussion in this exercise involves methods of ensuring confidentiality both when obtaining information from current service providers and when using the obtained information within the direction service center. Discussion of release or authorization forms, standard operating procedures dealing with information security, and disposition of records is included in this exercise.

Issues for Discussion

Issue

What procedures would you use to ensure compliance with confidentiality standards when obtaining information from the child's present service provider(s)?

Discussion

The first task for the referral specialist is to obtain records from the present service provider(s). If the parent takes responsibility for having these records sent to the direction service center, the referral specialist will need to secure no written authorization. However, in this case the referral specialist will need to discuss the child with staff members from the residential center, so authorization to release information should be secured from the parent. Only the specific information necessary to assist the referral specialist in locating services should be requested, e.g., educational records, results of past medical or psychological evaluations. Written authorization in the parents' primary language is suggested.

Local direction service center policies will determine whether general or individual releases will be used. A general release authorizes the referral specialist to obtain data from any of the child's present or past service providers. An individual release specifies the agencies from which the referral specialist may obtain records. Each procedure has its own advantages. For example, a general release frees the referral specialist from having to secure the parent's signature each time it becomes necessary to request records from a different agency or individual. An advantage of individual releases is that they let the parent know in advance exactly which sources will be tapped for information about the child. This procedure affords added protection to both the referral specialist and the parent, but it can cause delay if it becomes necessary to request information from an agency not listed on the original release.

In some cases, a parent may not want the present service provider to know that different services are being sought. Parents sometimes fear that if the service provider becomes aware of parental dissatisfaction, services will be discontinued. Since referring agents have the right to have their contacts to a direction service center kept confidential, a referral specialist should not attempt to obtain information from present service providers without the parents' or guardian's permission. Under these circumstances, the only recourse for the referral specialist may be to provide the information requested and make clear to the parent how these limitations can influence the information's appropriateness. If this situation existed in the sample case, the referral specialist would be limited to providing a list of residential schools for visually impaired children, but would not be able to determine those most appropriate for this particular child because he or she would lack specifics about the child's current functioning and present program content.

Policies regarding releasing information differ among service providers. Some agencies will release information on the basis of authorization forms prepared by the direction service center. In other cases, an agency may refuse to release any information, verbal or written, unless its own forms are used. The flow of information can be made smoother if a referral specialist becomes familiar with the procedures used by major service providers in his or her area and develops working relationships with staff in these agencies.

Issue

What procedures would you use to ensure the confidentiality of information within your own direction service center?

Discussion

After the referral specialist has obtained a client's records, confidentiality within the direction service center becomes a concern. Information about children and their families must be protected and used only for the purpose of locating appropriate resources to meet their needs. Standard operating procedures must be developed regarding:

Maintaining the confidentiality of the information within the center. This issue involves decisions such as which staff member will have access to the files and whether to keep client's records in open or locked files.

Releasing the information to outside agencies when the referral specialist is determining the appropriateness and availability of services.

Retaining records from other agencies after services have been obtained for a child.

The confidentiality of files within the office may be of greater concern to local centers than to statewide or regional direction service centers. At a local level there is a greater possibility of damage from unauthorized persons identifying direction service center clients and their families. This may happen, for example, if a staff member leaves records on his or her desk rather than returning them to the files. Regardless of their level of operation, however, all direction service centers must take precautions to protect the confidentiality of clients and their families.

The second issue pertains to releasing information to potential service providers. Again, it is suggested that referral specialists acquire written authorization from the parents before discussing the case with outside agencies. However, before a release is obtained, the referral specialist may choose to discuss the child without mentioning any identifying information. Even when the referral specialist has written authorization to release complete client records, the information released should be restricted to that which has direct bearing upon obtaining services for the child. Anecdotal data related to family history and dynamics should be weighed carefully as to its relevance before being released.

The final issue regards the disposition of records at the direction service center after services for the child have been obtained. Some centers return all records, except those necessary for followup, to the original source. Other centers choose to retain all of the client's records. Maintaining a central depository of client's records at the direction service center can be a valuable service to families whose children have been the subject of many evaluations, reports, and case histories. It can help in long-range case management and prevent repetitive diagnostic workups. It also relieves the parents from the burden of maintaining these records in the home and provides extra protection against records being lost. Parents of preschool handicapped children often find this helpful, especially when their child is preparing to enter public school. However, for the service to be useful in these ways, the direction service center must keep the files current with input from both service providers and parents. As the direction service center takes on more clients and records accumulate, maintaining the central filing system will require an increasing amount of professional and clerical effort. Maintaining these files often requires a considerable amount of time for a statewide operation such as the State Direction Service Center.

Using the Resource Information Bank

The following exercise presents a case study of a six-year old child whose parents have asked the State Direction Service Center to locate appropriate resources. The usefulness of the information bank and precautions regarding the dissemination of this information are discussed.

Case History

The parents of a six-year-old girl contacted the State Direction Service Center. The child was nonambulatory and was suspected to have below-normal intelligence. Although the child could talk, the parents believe she will need speech therapy. Vision and hearing were within normal limits. The child has some use of her arms and can feed herself with the aid of special equipment. Physical therapy had been recommended by her physician. There were no medical or health problems.

The child lived with her mother and father in central Texas. The mother was planning on returning to school to complete course work for a bachelor's degree. The parents were requesting short-term residential treatment because the child would return home after the year it would take for her mother to complete her degree. The parents hoped that the public schools could provide educational services for the child after the one-year residential program. Another concern of the parents was the dependency the child was developing for her mother, which evoked feelings of frustration in the mother, who had devoted the last six years to caring for the child. The parents felt that a short-term residential program would both foster more independence in the child and provide the mother with a respite.

Based on the needs identified by the parents and referral specialist, several resources were selected for exploration to decide whether they were appropriate for the child.

Issues for Discussion

Issue

How would maintaining a comprehensive information bank help the referral specialist locate services for this child more efficiently? How does it help the referring agent?

Discussion

Maintaining a comprehensive information bank provides the referral specialist with a broad array of resources from which to begin the search for appropriate services. Detailed information about possible services helps the referral specialist screen potential resources so that those selected and presented for the family's consideration will more completely match the needs of the handicapped individual.

A center that maintains limited information about resources, i.e., names, addresses, and phone numbers, is limited in the data it can provide parents, which requires the referral specialist to spend valuable time contacting each resource to gather more information about the services it provides. Additionally, a referral specialist may inadvertently give the parent inaccurate information if procedures are not in place to insure some form of standardized data collection.

In the case history, a six-year-old nonambulatory child has been referred to the center; the child will require special equipment for mobility and for eating. The parents are looking for a residential treatment facility that provides speech therapy, physical therapy, and educational services. The work involved in contacting resources to meet the needs of this family would be extensive. On the other hand limited information is of little use in view of the special needs of this child.

The following examples show ways in which information may be presented by a referral specialist. They illustrate that incomplete information is of limited use to a family with multiple needs.

Example 1

"The Davis Center is a residential facility in Dallas, Texas. Its phone number is _______. I know it works with some retarded children, but I'm not sure what levels of mental retardation. We would need to check on that. I think it works with boys and girls around 6 years of age. I feel pretty sure all of the teachers are certified in special education. It offers other services, but I need to check on the details."

Example 2

"The Davis Center is a residential school in Dallas, Texas. Its phone number is ________. The staff works with five- to nine-year-old children who are functioning at the educably mentally retarded level. They also take nonambulatory children and serve a total of 35 children at full capacity. The staff includes eight certified special education teachers, three physical therapists, two psychologists, and two speech therapists. Child care staff is available 24 hours per day. Services offered in addition to residential treatment are special education, education diagnosis, medical diagnosis, parent/family counseling, speech and physical therapy. The program operates nine months each year, and private placement costs $900.00 per month with no sliding fee scale."

After reading the first example, one can better understand that providing incomplete information to a parent can cause confusion and create indecision on the part of that individual. The past experience of the State Direction Service Center has shown that the parents' ability to make responsible decisions regarding the selection of services increases in direct proportion to the quality and quantity of the information they receive regarding service options. The referral specialist has the responsibility of providing the referring agent with information which will maximize the client's ability to make responsible decisions. Maintaining a comprehensive information bank reduces the work of the referral specialist while increasing the parents' ability to make decisions.

Issue

What precautions should the referral specialist take before and during the presentation of resource information to the referring agent?

Discussion

Before presenting information to parents, the referral specialist should contact each resource to determine whether services identified on the survey form have changed or been discontinued. Due to changes in funding and agency priorities, programs are discontinued and new programs are added. Incorrect information can be harmful, particularly if a referring agent has accepted the responsibility for contacting and/or visiting certain resources. Referring to the case history as an example, the parents would certainly lose confidence in the referral specialist and center if they drove 200 miles to visit a facility that no longer provided services for nonambulatory children.

During the presentation of information to parents, the referral specialist should discuss the services of a resource in terms of facts rather than personal opinions. This is especially true when a choice must be made between two or more resources. Biasing the information in favor of a particular resource may create problems later if the parents become dissatisfied with the services. The parent has ultimate responsibility for the child and should make the final decision as to which resource can better meet their child's special needs.

Unavailable Services

The following case history presents a situation in which the services needed by a client are not available. The discussion which follows describes how the referral specialist dealt with this particular case and illustrates general strategies for handling similar situations.

Case History

The mother of a one-year-old girl contacted the direction service center requesting help for her child. The mother stated that her daughter Mary could neither sit up nor talk and that she had been born with the umbilical cord wrapped around her neck. She described the child as "more like a six-month-old than a one-year old." She also said that a local pediatrician had told her Mary might have cerebral palsy. He knew of no programs in the area which would accept a child of that age. Because the public schools offer no services to children under age three (except those with visual and/or hearing impairments), the doctor suggested that the mother call the State Direction Service Center.

The referral specialist asked the mother to have Mary's birth records sent from the hospital and her medical records sent from the pediatrician. Because the mother's description of Mary's current functioning suggested a significant delay in development, the referral specialist began to explore the possibility of placement in an infant training program. A manual search of the resource files yielded the names of several agencies which offer these programs. After obtaining a release from the mother, the referral specialist began to contact these agencies. The education service center in that region offered an infant training program in cooperation with certain local school districts; however, the school district within which the family resided did not participate in the program. The Mental Health/Mental Retardation agency which provides children's services to that portion of the state was housed in a state school more than 60 miles away. Although the family owned an automobile, the distance was too great for the child to attend the program regularly. The referral specialist located a private rehabilitation center in a nearby town, but the cost of its infant training program was more than the family could afford and the program required one of the child's parents to attend daily with the child. This was impossible because both parents held full-time jobs. Neither the referral specialist nor any service providers she contacted knew of other infant training programs in the area.

Issue for Discussion

Issue

At this point the referral specialist had explored all known programs in the area, and it was apparent that the needed service was not currently available to the child. What strategies can you suggest for dealing with this situation?

Discussion

When the services best suited to a client's needs are not available, the referral specialist's first priority is to help the family by locating alternative resources capable of providing interim services. The second priority is to help the family plan for the future care and treatment of the child. Long-range planning is especially important in cases that involve very young, handicapped children.

One approach to locate an alternate resource is to identify one or more individuals within the child's home and/or school who can be trained, if only informally, to provide some service to the child. Because in this case the child was not in school, the parents were logically chosen for training.

The referral specialist asked the education service center (ESC) to evaluate the child's development and to outline a limited program which could be implemented by the parents at home. The ESC agreed and offered to monitor the child's progress if the parents could bring her to the center periodically. Mary's mother took her to the ESC, where Mary was evaluated by an occupational therapist, and an exercise and stimulation program was designed for her. The mother was shown how to implement the program, and she was asked to bring Mary to the center monthly so her progress could be monitored and the program altered as needed.

Although the child was not receiving the benefit of a full infant training program, some assessment and remediation did occur. The occupational therapist's evaluation indicated that Mary was experiencing developmental delay which warranted intervention; however, residential placement was not necessary. This fact enhanced long-range planning because it indicated that the child would be able to receive appropriate services from the public schools when she reached age three. It is also possible that, in the interim, a service may become available to provide more comprehensive intervention than Mary's home program.

Although other solutions to the problem may have been feasible, the approach taken by the referral specialist in this example illustrates a strategy which may prove useful in other similar situations. If the child was school age, school personnel could have been trained to provide services to her. An advantage to this is that these personnel can help other children with similar problems, thereby creating a resource in the community.

Appendix A

DEVELOPMENTAL EVALUATION SERVICE INTAKE SHEET

Developmental Evaluation Service
Intake Sheet

Date ________________

Client Information

Name ____
Birthdate ________ Chronological Age ______ Sex _______
Ethnicity ________ Religious Affiliation _____________
Citizenship ______ Primary Language of Client _________

Family Information

Parent/Guardian _____________________________________
Legal Guardian ______________________________________
Client Living With __________________ Phone __________
Address ____________________________ City ___________
Total Number Members _______________________

Financial Information

1. Does parent/child receive any financial assistance from any agency or organization? (SSI, DPW, etc.)
 ____
 ____
2. Is there any insurance available? ________________
 ____

Nature of Problem

Presenting Problem(s) _______________________________
____
____
Reason for Referral _________________________________
____
____
Referrant ____________________________ Phone _________
Address ___________________________ Date ______________
Informant _______________________ Intake Worker _______
Relationship to Client ______________________________

Background

Developmental History (when did client acquire the following):

Ambulation

Language

Toilet Training

Self-Help Eating

Self-Help Dressing

Previous Testing

Date	Place	Type Test Used	Results

Previous Education/Placement

Date	School Agency or Job

Services Received	Problems or Reason for Leaving

Current Placement	Services Rendered	Problems

Medical Information

Pertinent Medical History and/or Diagnosis

Seizures

yes no Has client ever had convulsions or seizures?

yes no Does client currently have convulsions or seizures? (Specify types)

With convulsive disorder, but not further specified ______
Akinetic seizures ______
Autonomic ______
Focal - one-sided or local ______
Grand Mal - Major motor ______
Myoclonic - arching of back, sudden general stiffening, usually infantile ______
Petit Mal ______
Psychomotor ______
Mixed - two or more types or seizures having no definite category ______

How many seizures does client have with medication? ______ per day; per week ______

How many seizures does client have without medication? ______ per day; per week ______

yes no Is medication periodically evaluated? (If yes, how often?) ______

What is the name of the medicine and how much does he or she take?

Medication	Dosage (number and size)
Phenobarbital	
Dilantin	
Mysoline	
Diamox	
Mebaral	
Peqanone	
Calontin	
Milontin	
Tridione	
Zarontin	
Paradione	
Mesantoin	
Gemonil	
Phenurone	
Paraldehyde	
Elipten	
Dexedrine	
Desoxyn	
Meprobamate	
Librium	

yes no Any other medications taken?

Type ________ ________ ________
Reason ________ ________ ________

Health

yes no Does client have any chronic illnesses? (If yes, list) ________________________
____
____
____
____

Physical Constraints

yes no Does client have any physical constraints which will limit participation in activities? (If yes, specify)

Cerebral palsy	Poor balance and coordination
Visual handicap	Respiratory
Uses wheel chair	Cardiac
Uses crutches	Seizures
Uses braces	Other (specify) ________ ________________

Self-Help Skills

Eating

yes no Does client feed himself or herself independently as part of a routine? (If no, specify)
____
____

Fed by special means ________________
Fed by bottle/breast only ____________
Fed by spoon ________________________
Feeds self with a spoon, with assistance ____
Feeds self with a fork, with assistance ____
Feeds self with spoon, fork and knife, with assistance ________________________

Dressing

yes no Can client dress and undress him or herself as part of a routine? (If no, specify)

Fully dependent ______________________________

Requires physical assistance ______________

Requires supervision (instructions) _______

____

Requires guidance (reminding) _____________

Toileting

yes no Is client completely toilet trained, bladder and bowel, with no accidents, day or night, and can go as part of a routine, no reminding needed? (If no, specify)

Bladder

Not trained ____________________________

Partially trained ______________________

Occasional accidents, frequency: ______

____

Bowel

Not trained ____________________________

Partially trained ______________________

Occasional accidents, frequency: ______

____

Personal Hygiene

yes no Does client perform tasks in personal hygiene (i.e., bathing, washing hands, hair care) as part of a routine? (If no, specify)

Fully dependent ______________________________

Requires physical assistance ______________

Requires supervision (instruction) ________

Requires guidance (reminding) _____________

Mobility

How does client move from one place to another?

Does not move from place to place

Rolls, scoots, crawls

Not by walking - uses physical aids (wheelchair, etc.)

Walking - uses physical aids (crutches, braces, etc.)

Walking - no physical aids

Balance (describe) ____________________
Gait (describe) ______________________

Communication

Hearing and Vision

yes	no	not sure	Does client have a hearing problem?
yes	no	not sure	Has client ever had a hearing test? (If yes, indicate results)
			No hearing loss ____________
			Mild (15-30 db) ____________
			Moderate (30-60 db) ____________
			Severe (60-90 db) ____________
			Profound (90 - no response) ______
			Informant does not know ________
yes	no	not sure	Does client have a vision problem?
yes	no	not sure	Has client ever had a vision test? (If yes, indicate results)
			No vision loss ____________
			Totally blind ____________
			Legally blind ____________
			Nearsighted ____________
			Farsighted ____________
			Strabismus ____________
			Other ____________
yes	no		Were glasses prescribed for the client?
yes	no		Is client currently wearing glasses if prescribed? (If no, why not?) ____________________________

Systems of Communication

How does client express or communicate his or her needs?

Client does not communicate; has no sounds, gestures or words

Has only throaty sounds, i.e., "Ah," but are not used to communicate his or her needs

Uses different sounds to express hunger, pain, and anger

Uses gestures, but no meaningful sounds or words

Uses sounds like /bababa/, but the sounds do not stand for a person, object, or action

Uses one or two sounds that stand for a person, object, or action

Uses a few simple words and pointing

Single functional words, i.e., "Potty" or "TeeTee," "Drink" or "Juice"
Simple word combinations such as, "Go Potty," "I want milk," "foot hurt"
Simple controlling phrases, i.e., "I wanna go outside," "Get me some breakfast," "I need to potty," "Let's play ball."
Uses complete sentences of five or more words
Uses complete sentences and can tell you a believable story about an action picture.

Problems of Communication

yes no Is it hard for strangers to understand what your child says because of the way he or she talks? (If yes)

Client has limited or no speech and uses gestures
Sounds and/or words are hard to understand
Speech is too fast or too slow
Speech is too soft or too loud
"Stutters"
Voice is nasal, air escapes through nose while speaking or child sounds like he or she has a cold
Child echoes or repeats everything he or she hears

Maladaptive Behavior

Behavior Affecting Himself or Herself

yes no Does client engage in any self-injurious behavior? (If yes, circle the kinds of behavior and indicate frequency)

Head banging ______________________
Biting himself or herself ______________
Slapping himself or herself _____________
Scratching himself or herself ___________
Other (specify) ___________________

Does client have temper tantrums? (If yes, circle the kinds of behavior and indicate frequency)

Kicking ________________________
Screaming ______________________
Hitting ________________________

Throwing ______________________________
Crying ________________________________
Falling on floor ______________________
Other (specify) _______________________

yes no Does client engage in any ritualistic activities or behavior that he repeats over and over which seems to have no purpose? (If yes, circle the kinds of behavior that occur and the frequency)

Rocking back and forth __________________
Twirling sticks or other objects __________
Screaming ______________________________
Repeating meaningless words _____________
Waving fingers in front of face __________
Other (specify) _________________________

yes no Does client ever seem moody, withdrawn, or depressed? (If yes, circle behaviors that best describes the moods and the frequency)

Sits in room alone ______________________
Sits in corner and stares _______________
Cries for no reason _____________________
Other (specify) _________________________
____

yes no Does client have difficulty sticking to an activity, is he or she constantly on the move? (If yes)

How long can the client maintain his or her attention to an activity that he or she chooses and enjoys?
Seconds _____ Minutes ______ Hours ______
How long can the client stick to an activity someone else chooses?
Seconds _____ Minutes ______ Hours ______

yes no Does client have any unusually strong fears?

Strangers
Water
Animals
Small rooms
Locked doors
Dark areas
Heights
Other

Behavior Toward Others

yes no Is client bullying or aggressive toward others? (If yes, circle the statement most appropriate and indicate frequency)

Verbally bosses others ____________________
Uses abusive language ____________________
Hits at others ____________________
Pushes/Shoves others ____________________
Bites ____________________
Scratches ____________________
Kicks ____________________
Hits with other objects ____________________
Other ____________________

Social Behavior

yes no Does client lie? (If yes, specify behaviors)
Lies to avoid being blamed for something that he did, i.e., "breaking a glass?"
Makes up fantasy stories
Lies to avoid participating in an activity
Other ____________________
Frequency of lying ____________________

yes no Does client take things that do not belong to him or her? (If yes)
From whom?
  Other family members
  Other people
  Stores
  Others
Do there seem to be times when this behavior occurs more often than other times? (If yes, when?)
____
____
____
Types of things taken and frequency
  Candy ____________________
  Toys ____________________
  Food ____________________
  Clothes ____________________
  Cars ____________________
  Money ____________________
  Other ____________________

yes no Does client engage in any inappropriate sexual behavior? (If yes, describe behavior and indicate frequency)
____
____
____

yes no Does the client run away from home? (If yes)
  How often per year, per month, per week?

Is there a definite pattern to it?
Where does the child usually run? ________

yes no Does the client run away from other activities? (If yes, circle the most appropriate answer and indicate frequency)

School __________ Job _______ Other ________

How does client cooperate with other people or children in recreation (play)

- Shows no awareness of others or objects
- No cooperative play; manipulates small toys/objects to entertain self
- Plays with one person (adult or older child) cooperatively, i.e., "rolling a ball"
- Plays in same room with other children, but not cooperatively
- Beginning to cooperate with other children, but does not share well
- Can play cooperatively in small groups of two or three children, with limited amount of sharing
- Can take turns and is learning to play by simple loose rules (either simple structured games or give and take rules of play) e.g., "tag," "hide and seek"
- Cooperates in larger "team-type" groups with rules suggested
- Team concept of cooperation
  - Takes turns
  - Activity for whole group rather than for self
  - Helps others in group

Relationship to Others

How does client get along with others?

- Shows awareness of others, but does not interact
- Overtly resists interaction with others
- Does not voluntarily interact with others, but does not resist when asked to do so
- Interaction with others if negative, i.e., picks at one or more children, bullies them, or does things which cause others not to like him or her
- Interacts with one or two special friends, but is generally timid in a group
- Has special friends, interacts with others, but is hesitant to initiate meeting new people

Can make friends easily, interacts with others with little trouble
Other description ______________________

Relationship to Adults as Supervisors

Does client have difficulty responding to authority or supervision? (If yes, specify behavior and indicate frequency)
Stubborn, refuses to do what he or she is asked to do
Rebellious, outwardly and actively refusing to cooperate with someone in authority, such as walking out of the room, hitting at the adult ______________
Ignores supervision of adults, passively resists ______________
Initially resists adult supervision, but eventually can be persuaded to interact and follow instructions ______________
Occasionally resists adult supervision (usually verbal), but generally has a cooperative relationship with supervisor ______________
Has friendly and cooperative relationship with supervisor, rarely resists supervision ______________

Social Independence
(usually asked when mother or guardian seems over protective)

Personal Responsibility

yes no Does client have routine tasks he or she is responsible for completing on his or her own? (Find the statement best describing the client's contribution to helping with the chores)
Client does not try to help adults while they are doing tasks around the house
Client volunteers to help with tasks, but is not effective in helping perform the task
Client helps effectively with tasks if asked to help
Client voluntarily and effectively helps an adult with one or more tasks around the house, i.e., dusting, cleaning, washing dishes, setting or cleaning the table, making beds, etc.

Personal Management

yes no Can client go out during the day without supervision and without fear of his or her getting into trouble or going where he or she is not supposed to go? (If no, circle most appropriate)

Child has physical constraints which interfere with independence
Child is not allowed out of the house. Why?
____
Child can go outside in the yard, but must have supervision
Child can go outside in fenced area, no supervision needed
Child can go to selected neighbor's homes (or dorms) accompanied by someone
Child can go to selected neighbor's homes (or dorms) with someone watching him or her go
Child can go to selected neighbor's homes (or dorms) with one adult notifying the other - no direct supervision
Can client go to selected neighbor's homes (or dorms) unsupervised?
Client has freedom to go anywhere in his or her immediate neighborhood or campus
Client can go outside the neighborhood (or campus) with someone supervising him or her
Client goes to school on his or her own or to familiar places outside the immediate neighborhood without supervision

Transportation

yes no Does client have transportation available to attend community programs (private, public)
or
yes no Will client need transportation provided?

Vocational

yes no Is client in job placement or training?
(If yes, where?) ________________________________

Goals

What goals would you like to see your child accomplish in the near future?

Referral Specialist's Impression of the Informant

Family Assessment

Name of Client ______________________ Date __________

Age of Parents

Father __________ Mother ______ Single Parent _____

Children Living at Home

Ages _____, _____, _____, _____, _____, _____, ____

Other Family Members Living in the Home

Ages _____, _____, _____, _____, _____, _____, ____

Money

How do you feel about your money situation?

Desperate
Struggling
Worried
Not Worried
Can hire someone to help weekly in house
Can hire workers (greater expense)

School

How are your children in school?

Lots of problems (grades and behavior)
Some problems (grades and/or behavior)
No problems - OK
Doing well, source of pride to family, extra school activities
Doing very well, real source of family pride, participation in extra activities
Age________ ________________________
Age________ ________________________
Age________ ________________________
Age________ ________________________

Vacations

yes no Does your family ever get to take a vacation, including over-night trips away from home?

Usual time length ____________________________
Who participates ____________________________
Type of activities ____________________________

Recreation/Exercise

yes no Do any members of your family participate in recreation/exercise?
How often ______________________________
Who participates ________________________
Type of activities _______________________

Work

Father: ____________________ Job ______________
How does he feel about his work? _______________
Mother: ____________________ Job ______________
How does she feel about her work? ______________
____

Structured Activities

yes no Does your fmaily ever attend activities such as church, lodge meetings, boy scouts, girl scouts, etc.?
How often ______________________________
What activities __________________________
Who attends ____________________________

Extended Family

yes no Does your family gain support from family members living outside the home?
If yes, how? ____________________________
____
If no, why not? __________________________
____

Chronic Illness

How is your family's health? (Circle closest to the answer given)

No frequent illnesses
Frequent unspecified illnesses
Recurring illnesses (6 weeks or less per year)
Recurring illnesses more than 6 weeks per year
Chronic illness, including mental illness, that requires continued care
Terminal illness that requires constant care.

Other

Are there any other factors that may affect your family positively or negatively? Specify: ____________________

____

____

____

Appendix B

INFORMATION REFERRAL FORM

Level I

Information Referral Form

Level I

REFERRING AGENT:

REFERRING AGENCY:

ADDRESS:

ZIP: PHONE: DATE OF REFERRAL:

STAFF MEMBER:

WRITTEN NARRATIVE OF NATURE OF REQUEST:

NATURE OF REQUEST

DIAGNOSIS ( )

COUNSELING ( )

MEDICAL ( )

RESIDENTIAL ( )

FINANCIAL ( )

EDUCATION ( )

OTHER, ______________________________ Specify

____________________ Verbal ________________ Written

____________ Printout

Appendix C

TEXAS REGIONAL RESOURCE CENTER REFERRAL FORM

Level II and III

Texas Regional Resource Center
Referral Form
Level II & III

Name of Child ______________________________

Parents (Guardian) ______________________________

D. O. B. ______________________________

Address ______________________________

____

Phone ______________ Zip ______________

County ______________________________

School District ______________________________

Date of Referral ______________________________

Staff Member Referred ______________________________

Referring Agent ______________________________

Title ______________________________

_____ ISD _____ ESC _____ DPW _____ MHMR

_____ Legal _____ Medical _____ Parent

_____ Other Address ______________________________

____

Phone ______________ Zip ______________

County ______________________________

ESC - Region ______________________________

Special Ed. Director ______________________________

Referring Agent's Description of the Problem:

____

____

____

____

____

____

Nature of Request: _____ Financial _____ Residential

_____ Ed. Programming _____ Medical _____ Diagnosis

_____ Other ____

____

Educational Background _______________________________

____

____

Medical History ______________________________________

____

____

____

Home Situation: (siblings/family problems, etc.)

____

____

____

Other Agencies Involved: (Diagnostics, Services, and/or Programs Attended)

Financial Considerations: (Funding for family, income, etc.)

CODES: HANDICAPPING CONDITIONS

A. No Handicap
B. Retarded
C. Hard of Hearing
D. Deaf
E. Speech Impaired
F. Visually Handicapped
G. Seriously Emotionally Disturbed
H. Orthopedically Handicapped
I. Other Health Impairments
J. Learning Disabilities
K. Multiple

SEVERITY

A. No Handicap
B. Mild
C. Moderate
D. Severe

CHRONOLOGICAL AGE

A. Under 5
B. 5-15
C. Over 15

Appendix D

STAFF TIME LOG

Staff Time Log

NAME: ____________________

WEEK ENDING: ____________________
(Use Sunday as end of week)

DAY OF WEEK	TIME (inclusive)	STRATEGY	EXPECTED OUTCOME UNITS (see workscope)

Appendix E

CONTACT LOG

CONTACT LOG

Staff Member________________

WEEK ENDING________________

DAY	MODE	CONTACT		ACTION	CONTACT TYPE	
☐ M ☐ T ☐ W ☐ Th ☐ F	☐ In Person ☐ In WATS ☐ In FTS ☐ In Local ☐ In Long Distance ☐ Out FTS ☐ Out Local ☐ Out Long Distance	☐ Group Contact: Attendance____ ☐ Individual Contact ------------------------ ☐ Other RRC ☐ Other Dir.Svc. ☐ BEH ☐ TEA ☐ ESC______ ☐ Consultants	 ☐ Parent ☐ Dir.Svc.Client ☐ LEA ______ ☐ Univ.______ ☐ Other ☐ TLRC	☐ They request ☐ We request ☐ They provide ☐ We provide	☐ Infor.Diss. on Appraisal and/or Ed.Programming ☐ Consultation: workshops or presentation ☐ Consultation: projects & products ☐ Consultation: for Indiv. Programming ☐ Consultation: Admin.	☐ CRS Interview ☐ General Infor. ☐ Descrip. of TLRC Svcs. ☐ Computer Search ☐ Staff/Professional meeting
☐ M ☐ T ☐ W ☐ Th ☐ F	☐ In Person ☐ In WATS ☐ In FTS ☐ In Local ☐ In Long Distance ☐ Out FTS ☐ Out Local ☐ Out Long Distance	☐ Group Contact: Attendance____ ☐ Individual Contact ------------------------ ☐ Other RRC ☐ Other Dir.Svc. ☐ BEH ☐ TEA ☐ ESC______ ☐ Consultants	 ☐ Parent ☐ Dir.Svc.Client ☐ LEA ______ ☐ Univ.______ ☐ Other ☐ TLRC	☐ They request ☐ We request ☐ They provide ☐ We provide	☐ Infor.Diss. on Appraisal and/or Ed.Programming ☐ Consultation: workshops or presentation ☐ Consultation: projects & products ☐ Consultation: for Indiv. Programming ☐ Consultation: Admin.	☐ CRS Interview ☐ General Infor. ☐ Descrip. of TLRC Svcs. ☐ Computer Search ☐ Staff/Professional meeting
☐ M ☐ T ☐ W ☐ Th ☐ F	☐ In Person ☐ In WATS ☐ In FTS ☐ In Local ☐ In Long Distance ☐ Out FTS ☐ Out Local ☐ Out Long Distance	☐ Group Contact: Attendance____ ☐ Individual Contact ------------------------ ☐ Other RRC ☐ Other Dir.Svc. ☐ BEH ☐ TEA ☐ ESC______ ☐ Consultants	 ☐ Parent ☐ Dir.Svc.Client ☐ LEA ______ ☐ Univ.______ ☐ Other ☐ TLRC	☐ They request ☐ We request ☐ They provide ☐ We provide	☐ Infor.Diss. on Appraisal and/or Ed.Programming ☐ Consultation: workshops or presentation ☐ Consultation: projects & products ☐ Consultation: for Indiv. Programming ☐ Consultation: Admin.	☐ CRS Interview ☐ General Infor. ☐ Descrip. of TLRC Svcs. ☐ Computer Search ☐ Staff/Professional meeting
☐ M ☐ T ☐ W ☐ Th ☐ F	☐ In Person ☐ In WATS ☐ In FTS ☐ In Local ☐ In Long Distance ☐ Out FTS ☐ Out Local ☐ Out Long Distance	☐ Group Contact: Attendance____ ☐ Individual Contact ------------------------ ☐ Other RRC ☐ Other Dir.Svc. ☐ BEH ☐ TEA ☐ ESC______ ☐ Consultants	 ☐ Parent ☐ Dir.Svc.Client ☐ LEA ______ ☐ Univ.______ ☐ Other ☐ TLRC	☐ They request ☐ We request ☐ They provide ☐ We provide	☐ Infor.Diss. on Appraisal and/or Ed.Programming ☐ Consultation: workshops or presentation ☐ Consultation: projects & products ☐ Consultation: for Indiv. Programming ☐ Consultation: Admin.	☐ CRS Interview ☐ General Infor. ☐ Descrip. of TLRC Svcs. ☐ Computer Search ☐ Staff/Professional meeting

Appendix F

LEVEL I and LEVEL II
SURVEY FORMS

DATE TAKEN____________ DATE ENTERED____________ SURVEYED BY____________

LEVEL I

IDENTIFYING INFORMATION

Name ____

Address ____

City __________________________ Zip ____________

Education Service Center Region ____________ County of Location ____________

County Catchment Area (includes county of location) ________________________

____

Telephone ____________ Auspices (check one): ☐ Public ☐ Private ☐ Proprietary

Check One If Appropriate: Direct Affiliation

- ☐ Texas Rehabilitation Commission (TRC)
- ☐ Texas Youth Council (TYC)
- ☐ Mental Health/Mental Retardation (MH/MR)
- ☐ Department of Health Resources (DHthR)
- ☐ State Commission For The Blind (SCB)
- ☐ Department of Human Resources (DHnR)
- ☐ Department of Community Affairs (DCA)
- ☐ Social Security Administration (SSA)
- ☐ Veterans Administration (VA)
- ☐ Texas Education Agency (TEA)

Executive Director____

Accreditation____

Special Referral Procedures ________________________________

SERVICE CLASSIFICATION

	MODE		
	Direct	Subcontracted	Support
ADVOCACY			
☐ Information and Referral			
☐ Legal Assistance			
AID			
☐ Equipment			
☐ Financial			
☐ Housing			
CAMPING			
☐ Day Camping			
☐ Overnight Camping			
COUNSELING			
☐ Psychological			
☐ Parent/Family			
☐ Vocational			
☐ Para-Professional/Volunteer			
☐ Genetic			
☐ Telephone Hotline			
DAY CARE			
☐ Day Care			
DIAGNOSIS			
☐ Educational			
☐ Psychological			
☐ Psychiatric			
☐ Vocational			
☐ Visual			
☐ Audiological			
☐ Medical			
☐ Total			

	MODE		
	Direct	Subcontracted	Support
EDUCATION			
☐ Regular			
☐ Remedial			
☐ Parent			
☐ Basic Life Adjustment			
☐ Special			
☐ Infant Development			
GENERAL MEDICAL			
☐ General Medical			
RESIDENTIAL			
☐ Detention			
☐ Foster Care			
☐ Care			
☐ Treatment			
☐ Respite			
☐ Halfway House			
SOCIAL/RECREATIONAL			
☐ Social/Recreational			
THERAPY			
☐ Physical			
☐ Occupational			
☐ Psychotherapy			
☐ Speech			
☐ Chemotherapy			
TRANSPORTATION			
☐ Transportation			
VOCATIONAL			
☐ Sheltered Employment			
☐ Vocational Training			
☐ Job Placement			

LEVEL II

Parent Organization____

SERVICE CLASSIFICATION

	MODE*		
	Direct	Subcontracted	Support
ADVOCACY			
☐ Information and Referral			
☐ Legal Assistance			
AID			
☐ Equipment			
☐ Financial			
☐ Housing			
CAMPING			
☐ Day Camping			
☐ Overnight Camping			
COUNSELING			
☐ Psychological			
☐ Parent/Family			
☐ Vocational			
☐ Para-Professional/ Volunteer			
☐ Genetic			
☐ Telephone Hotline			
DAY CARE			
☐ Day Care			
DIAGNOSIS			
☐ Educational			
☐ Psychological			
☐ Psychiatric			
☐ Vocational			
☐ Visual			
☐ Audiological			
☐ Medical			
☐ Total			

	MODE*		
	Direct	Subcontracted	Support
EDUCATION			
☐ Regular			
☐ Remedial			
☐ Parent			
☐ Basic Life Adjustment			
☐ Special			
☐ Infant Development			
GENERAL MEDICAL			
☐ General Medical			
RESIDENTIAL			
☐ Detention			
☐ Foster Care			
☐ Care			
☐ Treatment			
☐ Respite			
☐ Halfway House			
SOCIAL/RECREATIONAL			
☐ Social/Recreational			
THERAPY			
☐ Physical			
☐ Occupational			
☐ Psychotherapy			
☐ Speech			
☐ Chemotherapy			
TRANSPORTATION			
☐ Transportation			
VOCATIONAL			
☐ Sheltered Employment			
☐ Vocational Training			
☐ Job Placement			

*Direct and support modes cannot be checked for the same service.

SPECIAL MODES

Mobile______

Emergency______

FEE INFORMATION

Are Services Free to Client?

☐ Yes, always

☐ No

☐ Sometimes

Describe conditions for lowered fees or free service: ______________________________

Maximum fee per service unit:__________ per__________

Sliding fee scale? ☐ Yes ☐ No

Service wait:

☐ Within 48 hours

☐ Less than one month

☐ More than one month

Duration of Service:

☐ Limited

☐ Unlimited

TYPE OF CLIENT SERVED BY ABOVE SERVICE
RESTRICTED TO:

	Client Type	Age, Sex, and Other Eligibility – (Must be . . .) – *Do not exceed 50 spaces*
☐	Autistic	
☐	Blind and Deaf	
☐	Child with Cerebral Palsy	
☐	Children in Need of Supervision	
☐	Delinquent	
☐	Dependent Neglected	
☐	Drug Abuser*	
☐	Emotionally Disturbed	
☐	Epileptic	
☐	Hearing Impaired	
☐	Health Impaired	
☐	Language/Learning Disabled	
☐	Mentally Retarded, Educable	
☐	Mentally Retarded, Trainable	
☐	Mentally Retarded, Profoundly	
☐	Minimal Brain Injured	
☐	Multiply Handicapped	
☐	Orthopedically Handicapped	
☐	Speech Impaired	
☐	Visually Impaired	

*Drug abuser includes alcoholics; specify under "Other Eligibility"

LEVEL II

page 3

PROGRAM INFORMATION

Name of Program: ____________________

Name and Title of Program Director: ____________________

Intake Phone Number: ____________________

Address: ____________________

Brief Description of Service: ____________________

Average Duration of Program: ____________________

Hours and Days of Operation: ____________________

Staff:

Numbers Types Qualifications

Provide direct service for non-English speaking child? Yes ____ No ____

Types Language

Legal limitations to certain income levels? _____ Which? ____________________

Legal limitations to certain geographic areas? _____ Which? ____________________

How many can be served at full capacity? ____________________

How a referral is made if different from parent organizations: ____________________

____________________ Respondent: ____________________

Comments: ____________________

Appendix G

RRC CONSUMER FEEDBACK FORM

Level I

Number ____________________

Date ____________________

RRC Consumer Feedback Form

Level I

Staff member responding to request ____________________

In general, how satisfied were you with the way in which your request was handled by the RRC?

Highly		Satisfied		Dissatisfied
1	2	3	4	5

If dissatisfied, state reasons: ______________________

____

____

____

____

Did you request a computer print-out?

Yes No

If yes, how useful was this print-out? ________________

____

____

Please suggest ways that the RRC could improve its services.

____

____

____

Appendix H

RRC CONSUMER FEEDBACK FORM

Level II and III

I. D. Number ___________

Date ___________

RRC Consumer Feedback Form

Level II and III

Name of Child ____

Staff member handling referral ________________________

In general, how satisfied were you with the way in which your referral was handled by the RRC?

Highly		Satisfied		Dissatisfied
1	2	3	4	5

Name of agency/person to whom you were referred _______

____

How satisfied were you with the agency/individual's service to which you were referred?

Highly		Satisfied		Dissatisfied
1	2	3	4	5

If dissatisfied, state reasons: ______________________

____

____

Please suggest ways that the RRC could improve its services:

____

____

____

Follow-up: 1 month ____ 6 month ____ 12 month ____

Appendix I

DEFINITIONS OF CATEGORIES AND SUBCATEGORIES OF SERVICES

Definitions of Categories and Subcategories of Services

Advocacy

These services support and facilitate aid to children though they are not necessarily direct services.

Subcategory

Info and Referral - Acquaints clients with available resources and directs them to services appropriate to their needs.

Legal Assistance - Information given regarding legal matters by a lawyer or legal para-professional.

Aid

Subcategory

Equipment - Services providing prosthetics and/or crutches, glasses, hearing aids, etc.

Financial - Services providing cash income on a regular basis as well as those providing emergency funds.

Housing - Services providing assistance in securing housing and/or help in resolving conflicts between landlord and tenant.

Camping

Subcategory

Day Camping - Service providing care and camping experiences for children on a daytime basis.

Overnight Camping - Service providing camping experiences specifically geared for handicapped children. This may include wilderness camping trips and camping at permanent facilities.

Counseling

Subcategory

Psychological - Helping clients adjust to life situations and resolve emotional/behavioral problems. This may be offered by a psychologist, social worker, school principal, etc., but will not include therapy done by MD psychiatrist.

Parent/Family - Helping parents to understand and manage their child's problems.

Vocational - Informing clients of employment alternatives, helping clients assess their own vocational attitudes and aptitudes, and helping clients make decisions as to what types of training and/or jobs to pursue.

Paraprofessional/Volunteer - Services in which counseling, assistance, and/or advocacy are delivered to clients via paraprofessionals, peers, volunteers, etc.

Genetic - Counseling and/or medical intervention with high risk populations who have or are suspected of having physical and/or mental problems which are genetic in origin.

Telephone Hotline - Counseling, information, and referral on an emergency basis by telephone. These services are by definition "direct" and "emergency" in mode.

Day Care

Subcategory

Day Care - Custodial care for children outside their own home on a daytime basis.

Diagnosis

Subcategory

Educational - Evaluation of the individual and his or her needs through educational testing. This may include language assessment and speech testing.

Psychological - Furthering the understanding of the individual and his or her needs through the use of psychological assessment techniques.

Psychiatric - Psychological and physical testing done by psychiatrist.

Vocational - Helping an individual identify his/her career aptitudes, interests, skills, desired job placements, or fields of study.

Visual - Evaluation of an individual's vision.

Audiological - Evaluation of an individual's hearing abilities.

Medical - Evaluation of the individual and his or her needs through administering various medical tests, i.e., either gross screening or detailed in-depth testing procedures.

Total - In-depth evaluation of an individual by a multidisciplinary team so as to achieve an integrated picture of the client's needs.

Education

Subcategory

Regular - Educational services in which the instructional content and techniques are appropriate for the clients' chronological age group.

Remedial - Classes or one-to-one tutoring developed to enable a person to attain a normal level of educational achievement.

Parent - Structured, formal classes for parents of children with emotional and/or physical disorders.

Basic Life Adjustment - Teaching communication, self-help and/or prevocational skills. This will include programs emphasizing specific compensatory skills such as orientation and mobility, sign language, braille, etc., as well as many "day treatment" and "day activity" centers whose focus also includes social/interpersonal skills.

Special - To provide appropriate educational opportunities for persons whose handicapping condition has made it difficult or impossible to progress in a normal classroom setting.

Infant Development - Programs focused on early identification and intervention with developmentally delayed infants.

General Medical

Programs providing general medical diagnosis and treatment services. This will include general hospitals and private clinics.

Residential

Subcategory

Detention - To confine juveniles who have been charged with the commission of an offense and/or convicted of an offense.

Foster Care - To provide care in an agency-supervised home, together with treatment of problems of child and parents, for children whose parents are unable to care for them adequately because of social, emotional or health problems of child and/or parents and who can benefit from family life situations.

Care - To furnish proper and adequate maintenance care with little treatment focus.

Treatment - To provide a treatment-focused, controlled, group living environment geared to the specific needs of the individual.

Respite - Care provided for children whose parents temporarily cannot provide for them because they are undergoing some type of stress. There is a need for the children to be removed so both parents and children can rest and the children can be re-evaluated.

Halfway House - Residential facility housing 25 clients or less and providing treatment-focused programming as an intermediate placement between institutionalization and totally independent living. Some programs in this subcategory represent the only remaining alternative to institutionalization and may offer intervention and/or remediation for specific handicaps. Others are specifically designed for clients coming out of institutions and may emphasize community/family reintegration or maintenance strategies.

Social/Recreational

Services which are designed to be accessible to the handicapped and which offer opportunities for socialization and/or recreation. Examples of such programs could be Boy Scouts, Girl Scouts, athletic teams, clubs, picnics, and dances.

Therapy

Subcategory

Physical - The treatment of a physical disorder by providing exercises, manipulation of specific muscles, to alleviate pain and/or restore usage of affected area, by a registered physical therapist.

Occupational - The treatment of disease, injury or disorder by providing activities which may be defined as remedial, diversional and/or short-term. May be used to help individuals acquire job or self-help skills.

Psychotherapy - In-depth treatment of mental or emotional disorder or related bodily ills by psychological means. This can be by either Ph.D. psychologist or M.D. psychiatrist.

Speech - The treatment of disorders in language development and oral communication skills.

Chemo-therapy - Long-term, monitored drug treatment of physical or emotional disorders under the supervision of a licensed physician.

Transportation

To provide transportation services in order to enable consumers to take advantage of various social, educational, and/or health, medical services available.

Vocational Services

Subcategory

Sheltered Employment - To provide a controlled, protected, and limited work situation for the vocationally handicapped; to assist in psycho-social adjustment and vocational rehabilitation.

Vocational Training - To enable individuals to realize their optimum vocational potentials by equipping them with skills essential to the modern labor market.

Job Placement - Assisting a client in securing appropriate employment.

Appendix J

TYPES OF CLIENTS

Types of Clients

Autistic

A child of any age with severe disorders of communication and behavior whose disability became manifest during the early stages of childhood and whose handicap is not attributable to mental retardation or identifiable organic syndrome. The autistic child is characterized by severe deficits in language and ability to respond to his or her surroundings and participate appropriately in social relationships.

Blind/Deaf

A child who has both auditory and visual impairment, the combination of which causes such severe communication and other developmental and educational problems that they cannot properly be accomodated in special education programs either for the hearing handicapped child or for the visually handicapped child. This includes the rubella syndrome child.

Cerebral Palsy

A child who has any of a group of conditions affecting control of the motor system due to central nervous system or other neurological dysfunction.

CHINS (Child in Need of Supervision)

A child (10-17 years) who has been adjudicated by the Court and declared CHINS for engaging in conduct, other than a traffic violation, which on three or more occasions violates either of the following: (1) penal laws of this state of the grade of misdemeanor that are punishable by fines only, (2) penal ordinances of any political subdivision of this state, (3) the compulsory school attendance laws, (4) absent from his or her home voluntarily without the consent of parent or guardian for a substantial length of time or without intent to return, (5) an order of a juvenile court under Section 54.04 or 54.05 of the Texas Family Code.

Delinquent

A child (10-17 years of age) who has been adjudicated by the Court and declared delinquent because of conduct, other than a traffic offense, which (1) violates a penal law of this state punishable by imprisonment or by confinement in jail or (2) violates a reasonable and lawful order of a juvenile court entered under Section 54.04 or 54.05 of the Texas Family Code.

Dependent Neglected

A child who has been deprived of living conditions which provide minimal physical and emotional requirements for life, growth, and development. This is a Department of Human Resources term, and a child must be declared "dependent neglected" by the Child Welfare Department.

Drug Abuser

A child using nonprescribed mind-changing chemicals (including alcohol) to the point that his or her daily functioning has become impaired. This includes those cases where drug withdrawal might call for professional care.

Emotionally Disturbed

A child whose emotional/behavioral condition is medically and/or psychologically determined to be such that he or she cannot be adequately and safely educated in the regular classes of the public schools without the provision of special services.

Epileptic

A child who suffers from convulsive disorders in which recurrent disturbances of consciousness occur, with or without muscular components. The clinical symptoms may or may not be under the complete control of medication.

Hearing Impaired
(Deaf and Hard of Hearing)

A child whose hearing is nonfunctional for the purpose of understanding normal conversation, resulting in a delay in language or speech development or otherwise creating an educational handicap.

Health Impaired

A child with physical condition(s) and or special health problems which result in the need for special provisions for educational purposes. This may include children with chronic illnesses not specified on our type of child grid such as asthma, premature infants, heart defects, metabolic disorders, etc.

Language and/or Learning Disabled

A child who is so deficient in the acquisition of language and/or learning skills including, but not limited to, the ability to reason, think, speak, read, write, spell, or to make mathematical calculations, that he or she must be provided special services for educational progress. The LLD child's total intellectual functioning is not more than two standard deviations below the mean.

Mentally Retarded

Educable

A child whose measured intelligence is approximately 55-70 and whose measured adaptive behavior is significantly lower than the average for the chronological peer group. Educational programs for this type of handicap typically emphasize academic, social, and vocational skills adequate to self-maintenance.

Trainable

A child whose measured intelligence is approximately 30-54 and whose measured adaptive behavior is significantly lower than the average for the chronological peer group. Educational programs for this type of handicap typically emphasize communication skills and simple work tasks under sheltered conditions.

Severe/Profound

A child whose measured intelligence is approximately 29 or less. Educational programs for this type of handicap are typically structured for those with minimal capacity to function in sensori-motor areas but who may be able to walk and acquire basic speech.

Minimally Brain Injured

A child who is normal or above normal in intelligence but who has learning difficulties directly attributable to an organic defect caused by a neurological condition.

Orthopedically Handicapped

A child who is physically disabled or has difficulty ambulating or moving due to neurological or neuromuscular disease or disability characterized by skeletal deformities of a crippling nature.

Speech Impaired

A child who has abnormalities of speech which impair communication due to problems with articulation, rhythm, voice, and/or receptive language.

Visually Impaired

A child who either has no vision or whose visual impairments after correction result in educational handicaps requiring special provisions for maximal educational achievement.

Multiply Handicapped

A child who is considered handicapped by exhibiting two or more of the following conditions: visual, speech, orthopedic, hearing, or other severe health impairment; minimal brain injury; mental retardation; language/learning disability; epilepsy; emotional disturbance; and cerebral palsy.

Appendix K

SURVEY RESPONDENT THANK YOU LETTER

Texas Education Agency

201 East Eleventh Street
Austin, Texas
78701

- STATE BOARD OF EDUCATION
- STATE COMMISSIONER OF EDUCATION
- STATE DEPARTMENT OF EDUCATION

Thank you for giving the State Direction Service Center (SDSC) information about your organization. The SDSC uses this information to help the parents of handicapped children find the services their children need. Our staff members hope to visit many of the organizations we survey, and we may be contacting you for that purpose.

Because programs change, we update our information yearly. Meanwhile, if you have changes you feel we should know about, please call us. Our toll-free telephone number is 1-800-252-9668.

The SDSC is part of a statewide network of direction services. Enclosed are two fact sheets. The first describes the state, regional, and local direction service components, referral procedures, and contact persons at the regional level. The second describes our state-level component, the SDSC.

If you know of a handicapped child whose parents need help in finding services, please call the direction service center serving the area in which the child resides.

Sincerely,

Dennis Ferrell
Children's Resource Coordinator

Enclosures

"An Equal Opportunity Employer"

Appendix L

INFORMATION BANK REQUEST FORM

INFORMATION BANK REQUEST FORM

Date Information Requested: ______________________

Date Information Received: ______________________

By: ____
(staff member)

Client: ____

Number of Copies: ______________________________

PART 1

Type of Information	Qualifying Descriptors
1. Name	( ) ____________________
2. Address	
3. City	( ) ____________________
4. Zip	( ) ____________________
5. ESC Region	( ) ____________________
6. Phone	
7. Auspices	
8. Affiliation	( ) ____________________
9. County of Location	( ) ____________________
10. County Catchment	( ) ____________________
11. Service Category	( ) ____________________
12. Service Subcategory	( ) ____________________
13. Mode	( ) ____________________
14. Free Service	( ) ____________________
15. Maximum Fee	
16. Sliding Fee Scale	
17. Support Services	
18. Service Duration	
19. Service Wait	
20. Handicap	( ) ____________________
21. Eligibility	( ) ____________________

PART 2

ESC	( )	Name, Address, City, ESC, Category, Subcategory, Handicap, Eligibility
SERVICES	( )	Category, Subcategory, Handicap, Eligibility, Name, Address, City Phone
NAMES	( )	Name, Address, City, Zip, Category, Subcategory
COUNTIES	( )	Name, Address, City, Zip, Phone, Affiliation, County
CONTACT	( )	Name, Address, City, Phone, Category, Subcategory
RESOURCES	( )	Name, Address, City, Phone, Category, Subcategory, Handicap, Eligibility
HANDICAPS	( )	Handicap, Category, Subcategory, Mode, Name, Address, City, Phone
CATEGORIES	( )	Category, Subcategory, Mode, Handicap, Name, Address, City, Phone
FEE I	( )	Name, Subcategory, Free Service, Max Fee, Sliding Fee, Handicap, Eligibility, By Name
FEE II	( )	Name, Subcategory, Free Service, Max Fee, Sliding Fee, Handicap, Eligibility, by Subcategory
SUBCATEGORIES	( )	Name, Address, City, Zip, Phone, Subcategory, Handicap, Eligibility
RRC RESOURCES	( )	Subcategory, Handicap, Eligibility, Max Fee, Name, Address, City, Phone

OTHER ( ) HEADING

Appendix M

DATA STRING DESCRIPTIONS

Data String Descriptions

This appendix includes descriptions of three of the 12 data strings listed in Part Two of the Information Bank Request Form. Samples of computer output for each of the three strings accompany each description. When computer printouts are disseminated, a description sheet is included for each data string used in the printout.

Data String Description

Resources

This data string contains eight items of information on each resource arranged in eight columns across the page. Each item is listed and explained below.

1. Name of Agency - The names of resources identified as providing the service(s) specified in the request are listed alphabetically in this column.
2. Address
3. City
4. Phone
5. Service Category - The general types of services provided by the resource are listed in this column.
6. Service Subcategory - The particular subcategory of service within the general category is listed in this column. The definition of each subcategory can also be found in Appendix J. Users of this printout are urged to refer to these definitions, since they are in many cases more specific than those commonly used.
7. Handicap - The particular handicapping condition(s) for which the service is provided is listed here. The definitions of types of clients can be found in Appendix K.
8. Eligibility - The information shown here pertains to client eligibility requirements for each subcategory of service. Any specific age ranges served will appear first in this column, followed by any further eligibility requirements, such as restriction on sex of client or mobility of client (e.g., ambulatory).

RESOURCES

NAME	ADDRESS	CITY	PHONE	SERVICE CATEGORY	SUBCATEGORY	HANDICAP	ELIGIBILITY (must be...)
American Lung Association	2201 Blanco	Austin	(512) 238-9216	Advocacy	Information and Referral	Health Impaired	Respiratory Ailment
				Education	Parent	Health Impaired	Respiratory Ailment
Fairway House	4301 Avenue G	Austin	(512) 444-7863	Residential	Treatment	Cerebral Palsy	
						Mentally Retarded, Educable	
						Mentally Retarded, Trainable	
Parker Home for Girls	204 Barton Skyway	Austin	(512) 451-8795	Residential	Halfway House	Mentally Retarded, Educable	18+; Female; Ambulatory
						Mentally Retarded, Trainable	18+; Female; Ambulatory

Data String Description

Services

This data string contains eight items of information on each resource arranged in eight columns across the page. Each item is listed and explained below.

1. Service Category - Each general category of service specified in the request is listed alphabetically in this column.

2. Service Subcategory - The particular subcategory of service offered within the general category is listed in this column. The definition of each subcategory can be found in Appendix J. Users of this printout are urged to refer to these definitions, since they are in many cases more specific than those commonly used.

3. Handicap - The particular handicapping condition(s) for which the service is provided is listed here. The definition of types of clients can be found in Appendix K.

4. Eligibility - The information shown here pertains to client eligibility requirements for each subcategory of service. Any specific age ranges served will appear first in this column, followed by any further eligibility requirements, such as restrictions on sex of client or mobility of client (e.g., ambulatory).

5. Name of Agency - The names of resources identified as providing the service(s) specified in the request are listed in this column.

6. Address

7. City

8. Phone

SERVICES

SERVICE CATEGORY	SUBCATEGORY	HANDICAP	ELIGIBILITY (must be...)	NAME	ADDRESS	CITY	PHONE
Advocacy	Information and Referral	Dependent Neglected	0-16, Male	Methodist Home	1456 Andrews Road	Dallas	(214) 452-7163
Aid	Equipment	Orthopedically Handicapped	0-22	Children's Medical Center	926 Hamilton Freeway	Dallas	(214) 247-3823
Counseling	Psychological	Delinquent	13-22	Dallas County MHMR-CoCare	1521 Birchlawn	Dallas	(214) 635-0109
Counseling	Psychological	Emotionally Disturbed					
Diagnosis	Vocational	Delinquent	13+	Johnson Memorial Rehabilitation Center	2222 Pearl St.	Dallas	(214) 247-1765
Diagnosis	Vocational	Mentally Retarded; Educable					
Diagnosis	Vocational	Mentally Retarded; Trainable					

Data String Description

Handicaps

This data string contains eight items of information on each resource arranged in eight columns across the page. Each item is listed and explained below.

1. Handicap - Each handicap specified in the request is listed here in alphabetical order. The definitions of types of clients can be found in Appendix K.

2. Service Category - The general category of service provided for the handicap specified in the first column is identified here.

3. Service Subcategory - The particular subcategory of service within the general category is listed in this column. The definition of each subcategory can be found in Appendix J.

4. Mode - The information in this column refers to the method of service delivery.

5. Name - The name of the resource providing this service is listed here.

6. Address

7. City

8. Phone

HANDICAPS

HANDICAP	SERVICE CATEGORY	SUBCATEGORY	MODE	NAME	ADDRESS	CITY	PHONE
Emotionally Disturbed	Residential	Treatment	Direct	MHMR-Nueces County-Community Center	1630 South Brownlee	Corpus Christi	(512) 888-532
Emotionally Disturbed	Residential	Foster Care	Direct	Catholic Social Services	1404 Hemphill	Denton	(817) 492-032
Mentally Retarded, Profoundly	Residential	Care	Direct	Abilene Children's Center	1202 Jones Parkway	Abilene	(902) 672-439
Multiply Handicapped	Residential	Treatment	Direct	South Texas Children's Center	659 Jefferson	Edinburg	(817) 292-871

Appendix N

SPECIFIC ELIGIBILITY REQUIREMENTS

SPECIFIC ELIGIBILITY REQUIREMENTS

Below are samples of the statements which are sometimes used to qualify child types as to "other eligibility" (Level II survey form, page 2). Whenever possible, these statements are worded so that the phrase "the client must be..." is understood to preface the requirement. Some of these contain abbreviations to save computer space. The number of spaces required to enter each statement is in parentheses. Also included is a complete statement of the requirement without abbreviation and some clarification as to when it is used.

1. "Able to work w/min supv" (24)--able to work with minimal supervision; as in vocational programs or sheltered workshops where few supervisory staff members are available.

2. "Able to attend pub school" (25)--able to attend public school; as in residential care or treatment programs where no in-house educational services are available.

3. "Ambulatory" (10)--this refers to a child who is mobile and does not require special physical plant characteristics such as ramps instead of stairways, etc.

4. "Semi-ambulatory" (15)--this refers to a child with crutches, braces, a prosthetic device, or who is confined to a wheelchair. This includes the child who is able only to sit in a wheelchair and is incapable of self-propulsion.

5. "Non-ambulatory" (14)--this refers to a child who is totally immobile and bedridden.

6. "W/O need for med or hosp" (24)--without need for medication or hospitalization. This occurs with agencies where, for example, no supportive medical services are readily available.

7. "_______ grade"--for example, 8th, 9th or 10th grade.

8. "Voluntary" (9)--this occurs in connection with low security residential treatment services and also often with drug abuse counseling.

9. "City/Co/St res for ___ mos" (19, 17, 17)--city/county/state resident for ___ months. Used to describe residency requirements.

10. "Non-pregnant" (12)

11. "Less than ___ years at referral" (28)--this denotes the maximum age acceptable for admission into a program. In some cases a client must be less than a certain age at the time of admission, but once in the program can continue to be served past this age.

12. "W/O sev secondary h/cap" (23)--without severe secondary handicap. This is used with services in which a secondary handicap would interfere with the primary treatment program.

13. "W/parent participation" (23)--with parent participation. This often occurs with counseling or therapy services which require simultaneous parental involvement.

The following descriptors are used exclusively with the child types indicated and may not be used to qualify other child types:

Blind and Deaf

"Partially sighted" (17)

"Partial hearing" (15)

Emotionally Disturbed

"W/basic living skills" (22)

Epileptic

"Controlled by med" (17)--controlled by medication

Hearing Impaired

"Benefit from amplif" (19)--able to benefit from an amplification device.

"Familiar w/sign lang" (21)--familiar with sign language.

EMR)
)
TMR) "IQ of ___ or more/less" (16)--e.g., IQ of
) 70 or more; IQ of 50 or less
PMR)

Health Impaired:

The following is a sample of requirements currently used to qualify this child type.

"Arthritic" (9)
"Asthmatic" (9)
"Birth Defect" (12)
"Cancer Related" (14)
"Cardiovascular" (14)
"Developmental Delay" (19)
"Diabetic" (8)
"Hypoglycemic" (12)
"Neurological disorder" (14)
"Post-larengectomy" (17)
"Pregnant" (8)
"Premature Birth" (15)
"Rape" (14)
"Suspected _____" (Used for diagnostic services).

Appendix O

REFERRAL TRANSCRIPT

Referral Transcript

This transcript is from a conversation in which a child is referred to the State Direction Service Center. Portions of this transcript are used as the basis for training exercises for referral specialists.

RS=Referral Specialist F=Friend

RS: 1 Hello. This is ____ ________. May I help you?

RA: 2 My name is Mrs. Jones and I have a friend who has a little girl who has a real problem.

RS: 3 Let's talk about what you see as the problem.

RA: 4 Okay. Well, she was born dead and they revived her. They said she had brain damage at birth. She didn't have any convulsions to speak of, just a few until the last 3 months. Then the last 3 months she's had three. She trembles, sometimes she shakes real bad, and she also has something wrong with her ankles. She had surgery on her ankles when she was a little baby. Her feet turned, and she had braces with the bar in between when she was small. She's still supposed to wear braces in her shoes. Her doctor was amazed because she walked when she was a year old.

RS: 5 You mean despite all that she still walked at one year?

RA: 6 She walked when she was a year old despite everything. And they were just really amazed. She's been through a child study center and she's had all of the tests. You know everything that they do up there. I am not sure what was involved.

RS: 7 When was that? Do you remember?

RA: 8 I think she went through last year. She's been through more than once since she went through the first time.

RS: 9 Okay. I will be glad to contact her mother. How did you hear about us? I am just curious.

RA: 10 Well, I saw the signs, but there were no phone numbers on the signs. Her mother asked me if I would get the phone number. I told her about it, you know. Problem is, the doctor Crystal is going to now feels like she needs a private school because when she began in public school they put her in with retarded kids and problem children, and Crystal has always been well disciplined. Her parents haven't let the handicap make them lenient. They have disciplined her real well. They tried her in the public schools last year and she's failing. But from what I can gather, the class was real rowdy and nobody minded the teacher, and she would come home every evening sick, vomiting from nerves. So her mother put her in private school and she seemed to do better with her sickness. She didn't come home sick everyday, but I feel like they didn't really teach her what she needs to know. Of course she had a late start too.

RS: 11 You mean in this private school?

RA: 12 Yes. She only went the last three months of school and she hadn't learned anything in the public school. They wouldn't take the time to do anything with her in the public school, I don't think. Now, this is my own private, personal opinion. I talked to the principal. Me and her mother went up there, and he was just real ugly with me.

13 Tell me about it, would you please?

RA: 14 Well, we went up there to talk to him to see if there was another type class they could put her in. I asked some questions. I told him that she's going to fail if she stays where she's at, and I asked him if there was another private class. He turned around and looked at me and said, "Well, what's your deal in this?" Like I was nobody. But I have known the little girl since she was 9 months old, and I am close to her, and I am about the only person in the world that her mother will let her go with and not worry about her. I just want to see if I can get anything done.

RS: 15 Will she be staying in the same class that she was in before?

RA: 16 Yes. That's why Cheryl took her out and put her in a private school because they said they wouldn't change her. They would just leave her where she was.

RS: 17 Will you tell me something else, please? You're obviously extremely interested in this. Does the mother know that you were going to call me?

RA: 18 Yes. I called her a little while ago and told her I had your number. She asked me to see if you could call her today.

RS: 19 Okay. I can call her back this afternoon. Will you tell me a little more about Crystal yourself so that I can get an idea of some questions that I could ask her mom.

RA: 20 So far as mentally, she doesn't seem to be that retarded. She knows her colors, and I feel like in her mind knows it, but she can't get it on paper for her shaking and trembling. She can't color, she's real sloppy. She can't write because she trembles so bad. And that's her problem. Now that is the way I feel and I have been around her quite a bit. Like I said, I have a 7-year-old who is a couple of months younger than Crystal, and comparing the way they play, Crystal is not retarded.

RS: 21 So you think she can play with children her own age.

RA: 22 Yes. But she does have a voice problem. You have to really listen to understand her because of the trembling and all. But so far as grasping in her mind, I feel like she can do that just like my daughter.

RS: 23 Does she make good sentences when she talks?

RA: 24 Yes, she does. She talks real good. She can talk as good as mine. You know, if you can understand her. I mean as far as sentences and talking about things and knowing about things. She plays the record player even with the trembling. Her mother has gotten her a good record player. She sings songs right along with the rest of the 7-year-olds.

RS: 25 It sounds as if you have some real insight into Crystal's problems, as well as her strengths. By the way, I did want to let you know that our agency is part of the Texas Education Agency. In fact, we are a special project of the Agency, which, as you may know, serves children and looks after all the educational programs around the state.

RA: 26 Well, that's why I called.

RS: 27 Now any information that you give me will be confidential and kept in our files. In fact, I am recording the information that you are giving me, and any information that you give me or that is sent to me from other agencies or is sent to me by the mother will be kept confidential. I have to have the mother's permission, in fact, before I talk to other agencies or other sources of information.

RA: 28 Well those signs about handicapped children are up all over, and I'm for anybody who is for the handicapped if they will do something. If they just take this all down and never help the child, then that makes me mad.

RS: 29 I promise you we will help. What we will do is get as much information as we can and link the mother with a local agency that can help. If no local agency can help, we will find an agency in her region. We will also follow-up to see that everybody is communicating properly.

RA: 30 Well, that's wonderful. I mean really, she has called people and they don't do anything. They take it all down and then nothing ever happens. We have known, her mother and I, that this was going to be a problem when she started to school.

RS: 31 Well, you are absolutely right in calling us. Let me see if I understand what has happened. She sought help from the school but they were uncooperative as far as you could see. It sounds as if the motor problems are preventing Crystal from doing the work like the other children. But that the school has not been very responsive to her special needs. Was she put in a class with other children?

RA: 32 Yes.

RS: 33 Was she with those other children constantly during the day?

RA: 34 Just like her normal classroom period. But the children in there seemed to be mostly discipline problems because they were loud. Now whether it was the teacher or the kids or what, Crystal wanted to get out real bad.

RS: 35 I am a little confused. You said she was in the class and supposedly doing what, first-grade work?

RA: 36 Yes. Supposed to have been, but it wasn't.

RS: 37 Were all the other children doing first-grade work?

RA: 38 Supposed to have been, but they weren't doing the same thing my girl was doing. She was in the first grade there.

RS: 39 How many children were in Crystal's room?

RA: 40 Well, there were about 30, and they all had problems of one kind or another. I mean, Crystal didn't get to letters and she was there six months. They colored, and Crystal, of course, can't color. So she never got any service. Now that is what I feel like is the problem. Crystal can do the work. She could do the reading. I told Crystal's mother she ought to get her a cheap little typewriter.

RS: 41 That is a fine idea.

RA: 42 I tried to get her to do it for all of last year, but she said no, she is too slow and she didn't think they would let her take it to school. I thought, well I mean, she can't write legibly and she can't color. I feel like she can do the work, but she is too slow.

RS: 43 In reading the literature and the advertisements, did you understand that we have these kinds of projects because handicapped children have the same right as other children to receive a free, public education?

RA: 44 I didn't read that off the sign, but I have always felt that way. I told Cheryl that it is just not fair that they do her that way. She can't really afford to put her in a private school. She has two other children.

RS: 45 Do they have any problems?

RA: 46 No. They are perfectly fine. But Crystal weighed nearly 12 pounds when she was born. Now that was a problem. When Cheryl got pregnant with the other two kids the doctor that she went to started giving her insulin shots. He said that this was to keep the baby from being so big. And her husband about had a fit. "How come somebody didn't tell us that seven years ago when she was pregnant with Crystal?" More than likely none of this would have ever come about if the doctor had given Cheryl the insulin shots when she was pregnant. The baby wouldn't have been so big, and she wouldn't have had such a hard time having her, and Crystal wouldn't have been born dead.

RS: 47 I see. Do you remember when she began to talk? Since you have a little girl her age, I imagine you have a good idea of normal child language development.

RA: 48 Well, she talked just about the same time mine did. Crystal walked six months before mine did, and there is nothing wrong with her. But she has real good grades this year in school, my little girl has. And her and Crystal play together. Crystal is bright. She really is. She just hasn't had a chance to show it. I even told Cheryl that Crystal could come to live with me and go to school up here in this big school district.

RS: 49 It sounds like you and Crystal's mother are concerned about the way Crystal has been handled in the school. Now I am not trying to defend the school, but perhaps there is a communication problem between the parent and the school. This sometimes happens when the special education people and the parents don't get together to discuss the problems. My inclination is to have the mother make an appeal to the persons in special education or perhaps even to the superintendent. If she doesn't want to do that, she certainly has a right to approach the Texas Education Agency and we can put her in contact with the proper persons. But we will take care of it in one way or another.

RA: 50 What will you do to help?

RS: 51 Well, first of all, we gather all the information about the child's past history and record it as accurately as possible. If a parent or someone else is complaining about the quality of service a child is receiving, we encourage them to appeal to the school and ask the school personnel to reconsider their child's educational program and perhaps to put the child in a different one. We always let the people know what their rights are as parents of handicapped children and maybe try to get them even involved with some of the local parent groups. We will follow the referral through until Crystal gets the services she needs. You see, the Texas Education Agency has what is called Plan A for special education, which funds school districts to encourage them to put the handicapped child back into the classroom as much as possible. Now Crystal's problems don't make her abnormal. She should be with other children her age as much as as possible.

RA: 52 I told Cheryl myself that Crystal would do better in a normal class if they would let her bring a typewriter or something to get work done.

RS: 53 I think you're right. I am also concerned about some other things. For instance, did she mention that she had some additional convulsions that she had not had before?

RA: 53 Well, she had one of her convulsions on me the other day.

RS: 54 What does she do when she has a convulsion?

RA: 55 It looks like a stroke.

RS: 56 Does she fall down when this happens?

RA: 57 Well, one whole side pulls. It looks like a stroke. Now I have never seen a stroke, but I have seen epilepsy convulsions and I have seen heart attacks but what she has to me looks like what I have overheard about strokes. One side of her face and mouth pulls and her arm and leg pulls and I don't know what cerebral palsy convulsions look like, I have never seen one of those.

RS: 58 Well, sometimes children with cerebral palsy can have convulsions because of the brain damage they have received at birth. Mrs. Jones, can you think of anything else that you would like to tell me before I call the mother? I am going to call her this afternoon.

RA: 59 Well, no, I can't really think of anything else right now. That's about it. I really do thank you for your help. I will tell Cheryl that you will call her today.

RS: 60 Thank you very much for calling us. We will keep you posted as to what is happening with Crystal and the school program.

GLOSSARY

GLOSSARY

Accountability

The process of record keeping and data analysis by which an organization documents the achievement of its objectives. This process includes a quantitative and qualitative analysis of the work effort.

Advisory Board

A group of persons selected from service agencies, clients, and/or the community which provides advice to an organization concerning its policies and procedures.

Advocate

A person or organization representing the interests of another person or group.

Anecdotal Information

Information not sufficiently important to warrant entry into the information bank, but which is noted and retained on the survey form.

Case Management

A continuum of activities which begins with the acceptance of a referral and continues through follow-up. These activities involve establishing the needs of a client, locating services to meet those needs, and following up to ascertain the continued appropriateness of the services the client is receiving. The responsibility for these activities is usually shared among the case managers.

Case Managers

The persons who have primary responsibility for identifying the needs of a handicapped person and locating services to meet these needs. Case managers for a particular referral are generally comprised of one or more of the following referring agent, parent, referral specialist, school personnel, or other case workers having knowledge of the handicapped person.

Client

The handicapped person who has been referred to the direction service center for help in locating needed services. Although the handicapped individual is the primary client, parents, guardians, school personnel, and other case workers also benefit from direction service and can be considered secondary clients. In some cases the parents of the child are directed to services themselves (e.g., family counseling, housing assistance).

Consumer Evaluation Form

The follow-up form sent to the parents and/or referring agent asking for their evaluation of the information provided or services located by direction service for a client.

Consumer Feedback

Information provided by the referring agent/parent regarding their satisfaction with the assistance provided by direction service staff members and the services provided by the resource(s) to which they were referred.

Contact Log

Record pertaining to the nature of staff contacts with people not employed by the center. These contacts may be by telephone, correspondence, or in person.

County Catchment Area

Counties which comprise the geographic area from which referrals may be accepted.

Data Entry

The process of putting information into a computerized information bank, usually by means of a remote terminal unit.

Data Processor

The person who enters information into the computerized information bank.

Data String

A pre-set sequence of frequently requested items of information which can be generated by the computer.

Data String Generation Errors

Mistakes resulting from typing errors made by the data processor at the remote terminal unit.

Descriptors

A set of terms which describes the elements of information contained in an information bank; used both for data entry and retrieval.

Direct Service

A primary service provided by a resource agency; one to which a client may be referred directly without participation in any other program or service as a prerequisite.

Education Service Center (ESC)

An intermediate education unit providing a link between state and local education agencies. In Texas the ESC helps local education agencies interpret state policies and provides training and technical assistance in a variety of areas.

Indexing

Assigning guide-words, descriptors, or subject headings to the information about service providers that is entered into the computerized information bank. This allows information about all resources having a single subject heading or a particular combination of subject headings to be printed out by the computer.

Information Bank

Information which has been organized in some logical, retrievable sequence or arrangement. It may be managed manually by files and catalogs or mechanically by computers.

Key Sort System

A method of information management in which data are coded to match designated holes around the outer edges of cards. Information is retrieved by inserting a pick or stylus into holes corresponding to the desired information.

Level I Referral

A request for general information pertaining to resources. Level I referrals do not involve a particular handicapped person. Referring agents requesting Level I assistance are usually affiliated with agencies which serve the handicapped in some way. Examples of Level I referrals include requests for information about individual agencies, lists of resources within a specified geographic area, or lists of resources offering services to a specified segment of the handicapped population.

Level II Referral

A request for assistance in locating services for a particular handicapped person. The referring agent assumes major responsibility for case management, with assistance from the referral specialist.

Level III Referral

A request for assistance in locating services for a particular handicapped person. Case management is shared between the referring agent and referral specialist.

Level I Survey

This one-page form contains items of information which apply to the agency as a whole, such as agency name, address, phone number. All services offered by the agency are indicated on the service classification grid of the Level I survey form.

Level II Survey

This three-page form contains items of information which apply to individual services offered by an agency. A Level II survey form is completed for each service which was indicated on the Level I form as being direct or subcontracted in mode.

Noneducational Services

Services which are not directly involved in the education of a child. Food, clothing, and shelter, although essential needs, are not directly related to the education of a child.

Needs Assessment

The referral specialist's determination of what services are required to educate a handicapped person and/or to remediate the handicap.

Pilot Program

The small-scale implementation of a model or concept used to discover and correct problems with the model before full-scale implementation.

Printout

The printed copy produced by a computer in response to a request for information.

Program

The service or constellation of services organized by an agency to meet the needs of its clients.

Qualitative Data

Information which indicates the quality of a service or product.

Quantitative Data

Information concerning some aspect of an operation that can be counted; number of contacts, of clients, of services available, amount of money or time expended, etc.

Referral Component

The element of a direction service center which matches the individual needs of handicapped persons to resources providing services to meet those needs.

Referral Specialist

The direction service center staff member who helps a referring agent locate appropriate services for a handicapped person.

Referring Agent (RA)

The person who contacts the direction service center for assistance in obtaining services for a handicapped person. The RA may be the handicapped person, a member of his or her family, a local professional, or even a friend of the family.

Remote Terminal Unit

A keyboard unit, similar to an electric typewriter, through which a computer may be contacted for the purpose of entering information into an information bank or requesting information already contained in the information bank.

Resource

An agency, clinic, organization, or certified professional providing services to handicapped persons.

Resource Component

The element of a direction service center responsible for gathering information about organizations, agencies, and other resources offering services to handicapped persons.

Resource Specialist

The direction service staff member who gathers information about resources which provide services to handicapped persons.

Retrieval

The process of submitting a request for information to the data processor, who retrieves the appropriate information in printout form from the computer.

Service

A single activity in which an agency engages to meet a specific client need or to reach a particular program goal.

Service Classification Grid

A list of all categories and subcategories of services included in the information bank. It is constructed so that check marks in the grid indicate both the services offered by an agency and the mode in which each service is delivered.

Sliding Fee

Fee based on the client's ability to pay.

Staff Log

Individual staff record which indicates how time is spent.

Support Service

A service other than the primary service provided by a resource; one which is offered in support of a primary service. For example, a diagnostic center may provide transportation to the center for its clients, but not accept referrals for transportation alone.

Subcontracted Service

A direct service a resource elects to provide that is beyond the scope of its staff or facilities and is delivered by another provider, usually on a fee-per-service basis, billed to the primary resource agency.

Storage Information

Information entered into the computerized information bank for retrieval at a later date.

Target Population

The persons for whom a service is intended.

Validation

Checking the accuracy of information collected by the resource specialist from the agency being surveyed; also refers to the accuracy with which the referral specialist has assessed the needs of the client.

Vertical File

A collection of resource surveys stored in upright file cabinets.

Zero-Reject Referral System

A system designed to help individuals locate services for persons who have exhausted all local resources.